

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF WISCONSIN

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SHEILA A. GARD,

Plaintiff,

COMMON GROUND HEALTHCARE COOPERATIVE,  
MOLINA HEALTHCARE OF WI, INC.,  
FOUNDERS INSURANCE COMPANY,

Involuntary Plaintiffs,

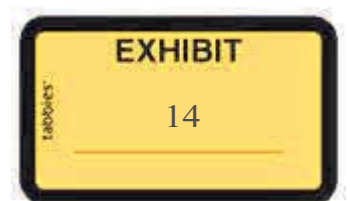
-vs-

Case No. 2:20-CV-256

UNITED STATES OF AMERICA,  
UNITED STATES POSTAL SERVICE,  
MARK CZECHOLINSKI,

Defendants.  
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Video Examination of SHEKHAR DAGAM, M.D.,  
taken at the instance of the Plaintiff, under and  
pursuant to the Federal Rules of Civil Procedure,  
before Sarah M. Gilkay, a Certified Realtime  
Reporter, Registered Merit Reporter, and Notary  
Public in and for the State of Wisconsin, at 4600 W.  
Loomis Road, Suite 101, Greenfield, Wisconsin, on  
February 23rd, 2022, commencing at 3:34 p.m. and  
concluding at 5:15 p.m.



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A P P E A R A N C E S

GRUBER LAW OFFICES, LLC, by  
Mr. Eric M. Knobloch  
100 East Wisconsin Avenue - Suite 2800  
Milwaukee, Wisconsin 53202  
Appeared on behalf of the Plaintiff.

UNITED STATES ATTORNEY - EASTERN DISTRICT, by  
Mr. Brian E. Pawlak  
517 East Wisconsin Avenue  
Milwaukee, Wisconsin 53202  
Appeared on behalf of the Defendants.

\* \* \* \* \*

A L S O P R E S E N T

Mr. Keke M. Lewandowski, paralegal

Mr. Jay Church, videographer

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\* \* \* \* \*

I N D E X

E X A M I N A T I O N

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BY MR. PAWLAK 41  
BY MR. KNOBLOCH 84

E X H I B I T S

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Attached to Original Transcript.	

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TRANSCRIPT OF PROCEEDINGS

THE VIDEOGRAPHER: Good afternoon.

We're going on the record. The time is 3:34 p.m. Today is Wednesday, February 23rd, 2022. Please silence phones and other devices not being used for the deposition, as they can interfere with the recorded audio. The deposition will continue to be recorded until all parties agree to go off the record.

This is media unit number one of the recorded deposition of Dr. Shekhar Dagam. This is taken in the matter of Sheila A. Gard, et al., versus United States of America, et al. This case is filed in the U.S. District Court for the Eastern District of Wisconsin, Case No. 2:20-CV-256.

Our deposition is being held at 4600 West Loomis Road, Suite 101, Greenfield, Wisconsin, 53220.

I'm not authorized to administer an oath, I'm not related to any party in the action, nor am I financially interested in the outcome.

If we can have counsel state their appearances and affiliation for the record,

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beginning with the noticing attorney, and then the court reporter will swear in the witness.

MR. KNOBLOCH: Eric Knobloch from Gruber Law Offices here on behalf of the plaintiff, Sheila Gard.

MR. PAWLAK: The defendant appears by Assistant United States Attorney Brian Pawlak. Also present is a paralegal from our office, Keke Lewandowski, common and ordinary spelling.

SHEKHAR DAGAM, M.D., called as a witness herein, having been first duly sworn on oath, was examined and testified as follows:

E X A M I N A T I O N

BY MR. KNOBLOCH:

Q Hello, Dr. Dagam. We're here today to talk about the care and treatment of Ms. Sheila Gard, including the treatment that you provided, with respect to an auto accident that occurred on March 24th of 2017. We're going to get into that treatment, but before we do so I would like to provide you an opportunity to introduce yourself to the Court.

What is your occupation and your specialty, please?

A Yeah. My name is Shekhar Dagam. I'm a

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1 **neurosurgeon, and my occupation is surgery of**  
 2 **different aspects of the central nervous system.**  
 3 Q How long have you been a neurosurgeon?  
 4 A **I've been in practice for over 20 years.**  
 5 Q What I have marked in front of you, Exhibit  
 6 No. 7, appears to be your CV.  
 7 Would you agree with that?  
 8 A **Yes.**  
 9 Q Did you have a chance to look over that in the  
 10 few minutes before today's deposition?  
 11 A **I did.**  
 12 Q And it appears to me that the board  
 13 certification area, this version that we're  
 14 looking at ends in 2018.  
 15 Have you maintained your board  
 16 certification from 2018 to the present, and are  
 17 you currently board-certified?  
 18 A **Yeah. Unfortunately the CV I think is an older**  
 19 **version, and so I'm board-certified currently.**  
 20 **It actually even has the business address as a**  
 21 **different address.**  
 22 Q Where did you do your undergrad and your medical  
 23 training and residency, please?  
 24 A **I did my undergrad at University of**  
 25 **California-Berkeley. I did my medical school at**

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1 **George Washington University. And then I did my**  
 2 **neurosurgery training at the Mayo Clinic, and**  
 3 **then I did some time for an intra-residency**  
 4 **fellowship at the University of Pittsburgh**  
 5 **Department of Neurosurgery.**  
 6 Q I may have already asked you this. How long  
 7 have you been employed as a neurosurgeon?  
 8 A **I've been practicing neurosurgery since I**  
 9 **graduated from my residency program in 2001.**  
 10 Q Give us some perspective as to your average week  
 11 or your average month, how often are you -- do  
 12 you have surgery days versus clinic days, and  
 13 how many surgeries would you say you perform on  
 14 an average week?  
 15 A **Yeah. So my practice is approximately**  
 16 **50 percent surgery, 50 percent clinic. So I**  
 17 **will spend between two to three days in the OR**  
 18 **per week, and then alternate weeks I would be**  
 19 **two to three days in the clinic. The average**  
 20 **number of surgeries I do varies from**  
 21 **year-to-year. There were years where I was**  
 22 **doing 10 to 12 surgeries a week. Now it's**  
 23 **closer to 6 to 8 per week.**  
 24 Q Do you maintain privileges at any hospitals and,  
 25 if so, where?

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1 A **I currently have privileges at Columbia**  
 2 **St. Mary's Ascension in Downtown Milwaukee. I'm**  
 3 **also -- I have privileges at the sister**  
 4 **hospital, which is in Ozaukee, Columbia**  
 5 **St. Mary's Ozaukee. I have privileges at**  
 6 **Watertown Memorial Hospital in the city -- in**  
 7 **the town of Watertown. And then there is an**  
 8 **outpatient surgery center called Milwaukee**  
 9 **Surgical Suites where I have privileges as well.**  
 10 Q We're here today to talk about treatment that  
 11 was received by Ms. Gard due to that March 24 of  
 12 '17 accident. Throughout the course of this  
 13 time period from that accident forward, have you  
 14 had an opportunity to draft a report, and is  
 15 that your report in front of you as Exhibit 8?  
 16 A **Yes, it is.**  
 17 Q Based on your report or your other knowledge,  
 18 what is your understanding of the accident that  
 19 Ms. Gard was in?  
 20 A **Well, she was in an accident which caused her to**  
 21 **have neck pain.**  
 22 Q Taking a look at your report there, Doctor, I'm  
 23 going to ask you a very general question, then  
 24 we're going to get into the specifics of  
 25 treatment.

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1 What are the injuries that Ms. Gard  
 2 sustained in the accident that ultimately led to  
 3 the cervical fusion that you performed?  
 4 A **So she developed neck pain after the car**  
 5 **accident, and -- and she ultimately ended up**  
 6 **having both non-surgical and surgical treatment**  
 7 **for the neck pain.**  
 8 Q What I've shown you -- or showing you here,  
 9 Doctor, has been marked as Exhibit 3. What I  
 10 did was take out some records from what will be  
 11 Plaintiff's Exhibit No. 1, which is the  
 12 certified medical records, and I took out  
 13 records that I think you and I will talk about  
 14 today. I highlighted some areas that I think  
 15 may be a topic of discussion, and I also Bates  
 16 stamped in the lower right-hand corner for the  
 17 sake of our discussion today, so we don't have  
 18 to flip around as much.  
 19 With that being said, I would like for  
 20 you to take a look at the first Bates stamped  
 21 page number 1.  
 22 Do you have that in front of you?  
 23 A **I do.**  
 24 Q All right. And this appears to be an urgent  
 25 care clinic from the date of the accident,

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1 March 27th of 17.  
 2 Can you tell from this document,  
 3 Doctor, what pain complaints Ms. Gard was  
 4 reporting at that time?  
 5 **A Yeah. She said that she was having bilateral**  
 6 **shoulder pain, as well as pain on the left side**  
 7 **of her head, and then she said additionally pain**  
 8 **included neck pain.**  
 9 Q If you can flip the page to Bates stamp number 2  
 10 there, this appears to be dated March 30th of  
 11 '17. The note is with a Dr. Amy Swift-Johnson.  
 12 Do you know her?  
 13 **A Not personally.**  
 14 Q All right. Can you explain the symptoms that  
 15 she appeared she was having at that visit,  
 16 please.  
 17 **A The doctor reports in here that she was having**  
 18 **continued bilateral neck pain, which is neck**  
 19 **pain on both sides. It was worse on the right**  
 20 **side. She was having pain also going into the**  
 21 **shoulder blades and going down the back.**  
 22 Q Okay. Would it be reasonable at that point  
 23 based on what you know, Doctor, for Ms. Gard to  
 24 undergo a series of physical therapy?  
 25 **A Yes. It would be very reasonable.**

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1 Q All right. What I would like to do is show you  
 2 Exhibit No. 4. We're going to go back to 3, but  
 3 let's just switch to 4. All right.  
 4 Do you see that note, Doctor?  
 5 **A Yes.**  
 6 Q And what's the date on that note?  
 7 **A April 30th, 2018.**  
 8 Q All right. I think I went out of order just a  
 9 bit. In any event, we're going to get to --  
 10 well, no. Let's stick on Exhibit No. 4.  
 11 What is the referral at that point  
 12 from the -- from the physician, based on  
 13 Exhibit 4?  
 14 **A Yeah. So in this note she recommends or says**  
 15 **that she can follow up with pain management.**  
 16 Q This is missing some pages. That's okay.  
 17 You're aware of Dr. Ong?  
 18 **A Yes.**  
 19 Q Who is Dr. Ong, and how do you know him?  
 20 **A So Dr. Ong is a physician who practices in pain**  
 21 **management. He works out of Aurora Lakeland**  
 22 **Hospital.**  
 23 Q Do you have a referral relationship with  
 24 Dr. Ong?  
 25 **A Yes. Yes, we do.**

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1 Q Okay. What I would like to draw your attention  
 2 to now is number 10 on Exhibit 3. This appears  
 3 to be date of service from June of 2018.  
 4 Do you see that?  
 5 **A I do.**  
 6 Q And under the operative procedure it says  
 7 "medial branch nerves."  
 8 Can you tell from this what procedure  
 9 it is that Dr. Ong is performing here?  
 10 **A Yeah. He's doing a block of the pain nerve**  
 11 **endings or fibers that go to the facet joints at**  
 12 **C4-5, C5-6, and so he calls it a medial branch**  
 13 **block.**  
 14 Q In your opinion what is the objective of such a  
 15 procedure?  
 16 **A The objective is to identify the location of the**  
 17 **neck pain. He makes a determination of where**  
 18 **the neck pain is based on exam, history, imaging**  
 19 **review, and then with that he'll decide where he**  
 20 **thinks the neck pain is coming from. He'll want**  
 21 **to have some sort of objective evidence to say**  
 22 **that that is where the pain is coming from, so**  
 23 **he'll do a block under X-ray to make sure that,**  
 24 **in fact, her pain is coming from that area.**  
 25 Q Flip to Bates stamp number 11 there. I have

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1 highlighted that Dr. Ong appears to be an  
 2 interventional pain management doctor.  
 3 Is that your understanding?  
 4 **A That is correct.**  
 5 Q Is it common in your experience, Doctor, for  
 6 someone who has neck pain who undergoes a series  
 7 of physical therapy and does not get relief to  
 8 then be referred to a pain management  
 9 specialist?  
 10 **A It's very common.**  
 11 Q What I would like to do now, at this point I  
 12 think we're starting to get into some of your  
 13 notes. Bates stamp number 12 there, Doctor, if  
 14 you could. The date on that is July 12 of 2018.  
 15 Do you see that?  
 16 **A I do.**  
 17 Q Do you believe this to be the first office visit  
 18 that you had with Ms. Gard?  
 19 **A I believe so.**  
 20 Q And what were some of the problems, if any, that  
 21 she was explaining to you at that point?  
 22 **A The main issue is she was having chronic neck**  
 23 **pain.**  
 24 Q If you flip the page to Bates stamp 13 there,  
 25 does this discuss some of the facet joint

<p style="text-align: right;">Page 14</p> <p>1 injections that she was having and talk about</p> <p>2 the relief that she was receiving, and, if so,</p> <p>3 can you explain that, please?</p> <p>4 <b>A Yeah. So she had the medial branch block, and</b></p> <p>5 <b>she reported she had at least 50 percent pain</b></p> <p>6 <b>relief.</b></p> <p>7 Q Can you explain in your experience, Doctor,</p> <p>8 the -- how typical is that, for someone to get</p> <p>9 50 percent relief? Is that typical? Atypical?</p> <p>10 Can you talk about that?</p> <p>11 <b>A I mean, if they're able to identify the proper</b></p> <p>12 <b>location and if the person is a reasonably</b></p> <p>13 <b>responding individual -- because some people</b></p> <p>14 <b>just don't respond to injections -- they should</b></p> <p>15 <b>at least get 50 percent, and it's very</b></p> <p>16 <b>reasonable to expect that.</b></p> <p>17 Q If you could now flip to page 17, which I think</p> <p>18 is the last or second-to-last page, maybe, of</p> <p>19 your visit.</p> <p>20 What was the plan or course of action</p> <p>21 that you establish with Ms. Gard at your first</p> <p>22 visit?</p> <p>23 <b>A So on our first visit we wanted her to maximize</b></p> <p>24 <b>her therapy with Dr. Ong, her treatments with</b></p> <p>25 <b>Dr. Ong. She had gotten relief with the facet</b></p>	<p style="text-align: right;">Page 16</p> <p>1 date of service from August 9th of 2018, and it</p> <p>2 looks like another operative note of sorts from</p> <p>3 Dr. Ong.</p> <p>4 Would you agree with that?</p> <p>5 <b>A Yes.</b></p> <p>6 Q And from this document could you tell what</p> <p>7 procedure we're talking about here?</p> <p>8 <b>A He says he's doing medial branch blocks.</b></p> <p>9 Q Is it common to -- for a patient to undergo</p> <p>10 multiple medial branch blocks?</p> <p>11 <b>A In fact, it is, because you want to be able to</b></p> <p>12 <b>have reproducibility to finding the location of</b></p> <p>13 <b>pain gene- -- to find the pain generator. It is</b></p> <p>14 <b>possible if you do it only once that you may</b></p> <p>15 <b>have just mistakenly thought that that's the</b></p> <p>16 <b>level, because sometimes the medication could</b></p> <p>17 <b>spread, sometimes you could be off. I mean,</b></p> <p>18 <b>there is so many different variables. So by</b></p> <p>19 <b>repeating it and getting the same result, it</b></p> <p>20 <b>increases the confidence of your original</b></p> <p>21 <b>findings.</b></p> <p>22 Q Okay. If you now flip to Bates stamp 20, and</p> <p>23 this appears to be another office visit from you</p> <p>24 dated August 22nd of 2018.</p> <p>25 Would you agree with that?</p>
<p style="text-align: right;">Page 15</p> <p>1 injections. Certainly it would have been</p> <p>2 reasonable for her to go back again. Because I</p> <p>3 think Dr. Ong and her had talked about a second</p> <p>4 round.</p> <p>5 I know that this was potentially</p> <p>6 leading toward a more permanent solution called</p> <p>7 radiofrequency ablation, which is the permanent</p> <p>8 version of the medial branch block, which is a</p> <p>9 more temporary version, and I had steered her in</p> <p>10 that direction. I felt that that was more than</p> <p>11 appropriate for her to try to find the least</p> <p>12 invasive method for pain relief.</p> <p>13 Q It also talks on number two here for the plan is</p> <p>14 to continue with Aleve.</p> <p>15 Would that be a -- something that --</p> <p>16 well, is that something you recommended at that</p> <p>17 time that she continue?</p> <p>18 <b>A Yeah. I mean, she was taking that, and then we</b></p> <p>19 <b>said, "You know what, that sounds great. You</b></p> <p>20 <b>know, if you're getting relief from that, let's</b></p> <p>21 <b>continue that." And I also said, you know, she</b></p> <p>22 <b>could try other therapies like Lidoderm patches</b></p> <p>23 <b>and so forth.</b></p> <p>24 Q If you could now turn to the next page, which is</p> <p>25 Bates stamped 18, Doctor. This appears to be a</p>	<p style="text-align: right;">Page 17</p> <p>1 <b>A Yes.</b></p> <p>2 Q Flip the page to Bates stamp 21 there. I take</p> <p>3 this to be part of the history and discussion</p> <p>4 that you're having with Ms. Gard at this visit.</p> <p>5 Is that a fair statement?</p> <p>6 <b>A Yes, it is.</b></p> <p>7 Q And what was your advice or what was the plan or</p> <p>8 course of action that you establish with</p> <p>9 Ms. Gard at that time?</p> <p>10 <b>A Yeah. So at that time she says her pain is a</b></p> <p>11 <b>little bit more tolerable. She said she didn't</b></p> <p>12 <b>have neck pain before the accident. She wanted</b></p> <p>13 <b>to know what would be a long-term option down</b></p> <p>14 <b>the road, and I think we had talked about</b></p> <p>15 <b>surgery. She wasn't interested in surgery at</b></p> <p>16 <b>that moment, and she thought that she could</b></p> <p>17 <b>continue to manage her pain without open</b></p> <p>18 <b>surgery. And we certainly were fine with that.</b></p> <p>19 <b>We, in fact, always support that whenever</b></p> <p>20 <b>possible.</b></p> <p>21 Q And perhaps my question would have been better</p> <p>22 served after we looked at page 25, so I'm going</p> <p>23 to have you briefly read the bottom highlighted</p> <p>24 part there, and can you let us know when you've</p> <p>25 had a chance to read that.</p>



<p style="text-align: right;">Page 18</p> <p>1 <b>A Okay. So in this paragraph we had a discussion</b>  2 <b>about the possibility of future surgery. And</b>  3 <b>even though she was managing -- and certainly,</b>  4 <b>again, we are supportive of that. It seemed</b>  5 <b>like she was always having breakthrough pain,</b>  6 <b>and I felt that at some point surgery may be</b>  7 <b>indicated.</b>  8 <b>Q But at this time in August of 2018, it was not</b>  9 <b>yet recommended by you, is that a fair</b>  10 <b>statement?</b>  11 <b>A I think at that point I didn't feel that she had</b>  12 <b>to have surgery. In her mind she wanted to</b>  13 <b>maximize everything nonsurgical, and I think</b>  14 <b>that there is so many factors that come into</b>  15 <b>making a surgical recommendation. When it's for</b>  16 <b>pain specifically, the patient has to be in that</b>  17 <b>mindset as well, and I think she wasn't.</b>  18 <b>And so we really knew that it was not</b>  19 <b>critical that she have surgery that day. It</b>  20 <b>wasn't like she was, you know, in the midst of</b>  21 <b>being paralyzed. We felt that since this would</b>  22 <b>be for pain that most likely she will need</b>  23 <b>surgery down the road, but that -- the timing of</b>  24 <b>that would have to be based on what she felt</b>  25 <b>comfortable with.</b></p>	<p style="text-align: right;">Page 20</p> <p>1 November 15 of 2018.  2 Do you see that?  3 <b>A Yes.</b>  4 <b>Q It appears that at least per this document that</b>  5 <b>it says "The patient has underlying facet joint</b>  6 <b>arthropathy."</b>  7 <b>Can you explain what that means?</b>  8 <b>A Yeah. So it just means there is disease or some</b>  9 <b>damage to the facet joint.</b>  10 <b>Q What is the procedure that is indicated here on</b>  11 <b>Bates stamp 33?</b>  12 <b>A Yeah. So this procedure he's describing is</b>  13 <b>radiofrequency ablation of the nerve endings</b>  14 <b>around the -- at or around the facet joints to</b>  15 <b>alleviate pain.</b>  16 <b>Q I've heard radiofrequency ablation is a nerve</b>  17 <b>burning procedure. Is there some correlation</b>  18 <b>there, or am I making that up?</b>  19 <b>A No. So, unfortunately, it's called nerve</b>  20 <b>burning. You're technically not burning any</b>  21 <b>nerves. You're destroying nerve endings, which</b>  22 <b>are pain receptors which are connected through</b>  23 <b>tiny filaments to the actual large nerve bundle.</b>  24 <b>So the large nerve bundle itself is not damaged.</b>  25 <b>Q Gotcha. If you could then flip to Bates stamp</b></p>
<p style="text-align: right;">Page 19</p> <p>1 <b>Q At that point in your opinion was it reasonable</b>  2 <b>for her to push off the surgery and try other</b>  3 <b>conservative --</b>  4 <b>A Absolutely.</b>  5 <b>Q -- remedies?</b>  6 <b>A Absolutely. Yes. Absolutely.</b>  7 <b>Q It appears here under the plan that you</b>  8 <b>recommend that she continue with Dr. Ong.</b>  9 <b>Is that a fair statement?</b>  10 <b>A Yes.</b>  11 <b>Q And then also order -- in plan three there it</b>  12 <b>looks like order another CT of the cervical</b>  13 <b>spine.</b>  14 <b>Is that to see if there is any</b>  15 <b>progression of her problem?</b>  16 <b>A Yeah. So one of the things that we can see in</b>  17 <b>CAT scans that we can't always see on MRI is we</b>  18 <b>can see damage that MRI won't show. So if there</b>  19 <b>is facet damage, which is the area that</b>  20 <b>Dr. Ong was injecting, we can sometimes see</b>  21 <b>black streaks in the facet joints, and that's</b>  22 <b>what I was looking for.</b>  23 <b>Q Gotcha. If we could then turn to page Bates</b>  24 <b>stamp 33, please. This appears to be an</b>  25 <b>operative note of Dr. Ong again dated</b></p>	<p style="text-align: right;">Page 21</p> <p>1 37, please. This is a date of service from  2 November 29 of 2018. It looks like another  3 radiofrequency ablation, although this one  4 targets the left side of C4, C5, and C6, whereas  5 the prior one was the right side.  6 Is that common for there to be two of  7 those procedures within a two-week time span,  8 one targeting each side?  9 <b>A Yeah. And this is probably based on Dr. Ong's</b>  10 <b>experience. He probably felt that he wanted to</b>  11 <b>try one side, see how effective it was, and then</b>  12 <b>go to the other side.</b>  13 <b>Q Are we still within the realm of what you would</b>  14 <b>call a reasonable course of care for Ms. Gard,</b>  15 <b>based on the injuries that you observed?</b>  16 <b>A Absolutely.</b>  17 <b>Q If we could now turn to Bates stamp number 39,</b>  18 <b>please. This appears to be another office visit</b>  19 <b>from your office dated December 5 of 2018.</b>  20 <b>Would you agree with that?</b>  21 <b>A I agree.</b>  22 <b>Q And then the stuff I want to talk about is on</b>  23 <b>Bates stamp 43, if you could flip to that, and</b>  24 <b>there is some stuff I highlighted on page 43 and</b>  25 <b>44.</b></p>

<p style="text-align: right;">Page 22</p> <p>1 Can you explain the recommendations</p> <p>2 that you made to Ms. Gard at that time, please.</p> <p>3 Well, let me back up. Let me withdraw</p> <p>4 the question.</p> <p>5 The first question I want to ask you</p> <p>6 is what was the discussion you were having with</p> <p>7 Ms. Gard at that time based on the feedback you</p> <p>8 were getting from her with the conservative</p> <p>9 treatment she had received up to that point?</p> <p>10 <b>A I mean, she was -- she was responding to the</b></p> <p>11 <b>injections and the radiofrequency. I mean, she</b></p> <p>12 <b>was getting better.</b></p> <p>13 Q Is it common for someone to have temporary</p> <p>14 relief from those radiofrequency ablations?</p> <p>15 <b>A Yeah. Absolutely. We can't promise how long</b></p> <p>16 <b>those will last. You know, sometimes they last</b></p> <p>17 <b>weeks, sometimes they last months, and anywhere</b></p> <p>18 <b>in between. So that's very much variable on the</b></p> <p>19 <b>person.</b></p> <p>20 Q The next page there I have one sentence</p> <p>21 highlighted. It appears now that the topic of a</p> <p>22 surgical procedure is starting to pop up.</p> <p>23 Is there any correlation between the</p> <p>24 timing of this, meaning you're now talking to</p> <p>25 her about surgery after she's done the</p>	<p style="text-align: right;">Page 24</p> <p>1 30 percent.</p> <p>2 I think we talked about it a little</p> <p>3 bit, but is that a common phenomenon you see in</p> <p>4 your patients that have these types of</p> <p>5 procedures?</p> <p>6 <b>A Yeah. I mean, there is certainly a temporary</b></p> <p>7 <b>nature to all these needle procedures and the</b></p> <p>8 <b>radiofrequency. I mean, it's possible that it</b></p> <p>9 <b>could have lasted longer. I mean, it's not</b></p> <p>10 <b>unheard of for it to last several months to a</b></p> <p>11 <b>year, and it's certainly possible that it only</b></p> <p>12 <b>lasts a few weeks.</b></p> <p>13 Q The last sentence that I highlighted, it says</p> <p>14 "Continues to have neck pain radiating to both</p> <p>15 shoulders."</p> <p>16 I understand that for you to evaluate</p> <p>17 what that really means you would want to see</p> <p>18 some imaging, but from a clinical standpoint</p> <p>19 with that comment there with her neck pain</p> <p>20 radiating to both shoulders, what does -- what</p> <p>21 does that indicate to you, if anything?</p> <p>22 <b>A It tells me that the area that was hurting from</b></p> <p>23 <b>the very beginning is still continuing to hurt</b></p> <p>24 <b>her at this point.</b></p> <p>25 Q The next document is -- that I would like to</p>
<p style="text-align: right;">Page 23</p> <p>1 conservative measures? Is that typical or</p> <p>2 atypical?</p> <p>3 <b>A It's very typical when the patient asks or if</b></p> <p>4 <b>the patient is concerned about long-term</b></p> <p>5 <b>management. And there was several issues that</b></p> <p>6 <b>came up. You know, she wanted to know what --</b></p> <p>7 <b>would she have to do radiofrequency over and</b></p> <p>8 <b>over, and I said certainly that would be</b></p> <p>9 <b>possible. She was concerned about, you know,</b></p> <p>10 <b>would surgery give her that permanency, and I</b></p> <p>11 <b>said yes. She wanted to know if there were any</b></p> <p>12 <b>risks, and I said absolutely.</b></p> <p>13 And so we kind of had all the</p> <p>14 different things, and it took multiple</p> <p>15 conversations to just finally sort of come to</p> <p>16 the conclusion that surgery was the thing that</p> <p>17 she wanted to pursue.</p> <p>18 Q Gotcha. If you can flip the page to page 45.</p> <p>19 This is an office visit from December 19 of 2018</p> <p>20 with Dr. Ong.</p> <p>21 Would you agree with that?</p> <p>22 <b>A I agree.</b></p> <p>23 Q It appears here that -- per this record that</p> <p>24 Ms. Gard obtained initially 50 percent pain</p> <p>25 relief from the procedure. Now she was down to</p>	<p style="text-align: right;">Page 25</p> <p>1 draw your attention to, Doctor, is Bates stamp</p> <p>2 number 48, please. This appears to be an office</p> <p>3 visit from February 27 of 2019.</p> <p>4 Would you agree with that?</p> <p>5 <b>A I agree.</b></p> <p>6 Q And then if you turn to Bates stamp number 53 on</p> <p>7 that, I highlighted some things, and it appears</p> <p>8 that from my recording of this page here that</p> <p>9 the option of surgery or the recommendation of</p> <p>10 surgery, you're getting closer to that.</p> <p>11 Can you comment on that?</p> <p>12 <b>A Yeah. I mean, I think at this point, you know,</b></p> <p>13 <b>she says she still has persistent symptoms.</b></p> <p>14 Q And I may interrupt. What were the symptoms per</p> <p>15 this note that she was reporting at that time?</p> <p>16 <b>A Well, pain in the neck going into the shoulder,</b></p> <p>17 <b>into the trapezius muscles, which is just</b></p> <p>18 <b>muscles between the shoulder and the neck, and</b></p> <p>19 <b>then pain going into the shoulder blade. She</b></p> <p>20 <b>feels that it just feels uncomfortable with just</b></p> <p>21 <b>normal daily activities. So those were the main</b></p> <p>22 <b>symptoms.</b></p> <p>23 Q I note here from my reading that the MRI appears</p> <p>24 that she has significant disease at C5 and C6.</p> <p>25 What do you mean by that?</p>

<p style="text-align: right;">Page 26</p> <p>1 <b>A I mean there is -- there is an -- there is --</b>  2 <b>the disc at C5-6 is abnormal, and based on where</b>  3 <b>the radiofrequency was, based on what the MRI</b>  4 <b>was, we felt that C5-6 was our target.</b>  5 Q Okay. The next note is page 54, if you can turn  6 to that. It appears that office visit is  7 October 30th of 2019.  8 Do you see that?  9 <b>A Yes.</b>  10 Q Flip the page here to page 56. It appears  11 now -- we're in October of 2019 -- that you are  12 now making the official recommendation of a  13 surgery.  14 Can you please confirm that's true,  15 and, if so, what surgery were you recommending  16 and why?  17 <b>A Yeah. We're recommending -- so we were</b>  18 <b>recommending a fusion surgery at the C5-6. We</b>  19 <b>recommended it from the front.</b>  20 Q Why?  21 <b>A The -- the disc at C5-6 appeared abnormal. We</b>  22 <b>can do a fusion at 5-6 from the front and get</b>  23 <b>the most stabilization of the C5-6 segment. We</b>  24 <b>could certainly approach it from the back of the</b>  25 <b>spine, which is the direction Dr. Ong went in</b></p>	<p style="text-align: right;">Page 28</p> <p>1 <b>we're -- we encourage every patient when we</b>  2 <b>discuss surgery to -- you know, just to take</b>  3 <b>some time out of the -- away from the doctor's</b>  4 <b>office and think it through. We, in fact, tell</b>  5 <b>every patient to do that.</b>  6 Q Okay. That brings us to page 58, if you can  7 flip to 58, please. That appears to be a visit  8 from you of November 20th of 2019.  9 Would you agree with that?  10 <b>A I agree.</b>  11 Q If you flip to the page 60 of that, it appears  12 now the plan is to actually go through with the  13 surgery.  14 Am I reading this correctly?  15 <b>A That is correct.</b>  16 Q And my guess is that this indicates Ms. Gard  17 thought about it for a period of time and  18 decided to call back and wanted to schedule the  19 surgery.  20 Do I have that right?  21 <b>A That is correct.</b>  22 Q All right. And then the next one that I would  23 like for you to turn your attention to is Bates  24 stamp number 66. That appears to be your  25 operative note of December 24th of 2019.</p>
<p style="text-align: right;">Page 27</p> <p>1 <b>with the needles. However, you have to disrupt</b>  2 <b>more muscle tissue, and the recovery is longer.</b>  3 <b>So often when a fusion needs to be</b>  4 <b>done and a choice -- you have a choice between</b>  5 <b>the front or the back, most surgeons opt for the</b>  6 <b>front because the recovery is faster and you</b>  7 <b>seem -- you can get a little bit stronger</b>  8 <b>stabilization.</b>  9 Q It appears from page 56 here that prior to  10 making that recommendation, you obtained some  11 more diagnostic imaging in the form of an MRI.  12 Is that true, and why did you do that  13 at that time?  14 <b>A I don't remember when her prior MRI was, but</b>  15 <b>typically we like to have a repeat MRI, if it's</b>  16 <b>been many, many months from the prior imaging,</b>  17 <b>just to see if there is any changes.</b>  18 Q And it appears that from page 56 here that this  19 was a situation where Ms. Gard didn't right away  20 say she wanted to have the surgery. To the  21 contrary, it looked like she wanted to just  22 think about it for a little bit.  23 Is that true, and is that a common  24 phenomenon you see?  25 <b>A Absolutely. It's super common. In fact,</b></p>	<p style="text-align: right;">Page 29</p> <p>1 Am I seeing that correctly?  2 <b>A That is correct.</b>  3 Q And using these documents and your memory and  4 your expertise, can you explain with as much  5 detail as you can the surgery that you performed  6 on Ms. Gard.  7 <b>A Yeah. So the procedure is called an anterior</b>  8 <b>cervical discectomy and fusion. What we do is,</b>  9 <b>after the patient is asleep on the table, we</b>  10 <b>make an incision in the front of the neck.</b>  11 <b>Using X-ray we identify the C5-6 level. We'll</b>  12 <b>put small distraction pins into the body. It's</b>  13 <b>just to open up the space a little bit to have</b>  14 <b>room to work in. We'll bring in a microscope so</b>  15 <b>we're able to magnify everything that we see.</b>  16 <b>And using instruments -- they're</b>  17 <b>called curettes -- we just curette out all the</b>  18 <b>disc space. We'll go to the back of the disc,</b>  19 <b>we'll identify any nerves that are there and</b>  20 <b>just check to see if the nerves are being</b>  21 <b>pinched, and we'll free them.</b>  22 <b>Once that's done, the bone where the</b>  23 <b>disc came from, we'll rough it up until we just</b>  24 <b>get tiny bits of bleeding so that it will be</b>  25 <b>likely to fuse.</b></p>



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1           We'll put a spacer in there, and the  
2   spacer can be anything the surgeon chooses,  
3   whatever works and whatever the patient prefers.  
4   Often we'll fill it either with the patient's  
5   own bone or something called allograft, which is  
6   cadaver bone.  
7           What I typically do is I do a mixture.  
8   I'll take bone from the surgery and then bone  
9   from a cadaver that's commercially available.  
10   We'll put it into the spacer, put it in there,  
11   and then we'll put a small plate that anchors  
12   everything together, and the plate is screwed  
13   into the bones.  
14 Q   So this was at C5 and C6, and I want to see if I  
15   have that correctly. This involves an incision  
16   into the front of the neck.  
17           Can you use your finger there, kind  
18   of --  
19 A   Yeah.  
20 Q   -- you point to where the incision is.  
21 A   So most surgeons will make an incision on the  
22   right side, so we'll find the midline midpoint  
23   at the neck -- in men, 5-6 is not far from the  
24   Adam's apple -- and -- and we'll just go to the  
25   right of that, and so we'll make a linear

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1   incision, like, right here.  
2 Q   And am I correct in hearing you that one of the  
3   first things you do -- I'm not going to say it's  
4   the first, but -- is you identify the damaged  
5   disc, and you remove that disc?  
6 A   Yes.  
7 Q   And then you fill that space with either cadaver  
8   bone or the patient's actual bone; is that  
9   accurate?  
10 A   Correct. And we'll put that inside a structural  
11   spacer that's usually like a small little  
12   cylinder or small little box.  
13 Q   And correct me if I'm wrong, but I'm going to  
14   assume the idea behind this is once you remove  
15   that damaged disc and replace it with bone, the  
16   idea is the body is going to naturally fuse  
17   together, those bones will fuse together  
18   naturally; is that right?  
19 A   That is correct.  
20 Q   Are there any plates and screws involved in  
21   this, or no?  
22 A   Yes. So --  
23 Q   Can you describe that, please.  
24 A   Yeah. So what we'll do is after we put the  
25   interbody -- which is a box or a little

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1   cylinder -- on top of the C5 and C6 bones, we'll  
2   put a small plate. And the plate is made of  
3   titanium metal, and then there will be little  
4   holes in the plate for screws to go in and  
5   anchor the plate to the bone.  
6           And typically these screws are -- we  
7   always use millimeter measurements, so they're,  
8   like, between 12 to 15 millimeters in length.  
9   And 25 millimeters is an inch, just to give you  
10   reference.  
11           And so we'll put these screws in.  
12   They'll go into the bone, they'll screw in,  
13   they'll lock the plate down, and that will  
14   provide a bracing. It will internally brace the  
15   bones together. Similar to someone who is  
16   wearing an external collar or brace, this is an  
17   internal brace that will hold it all together.  
18 Q   Am I correct in assuming that that bracing  
19   promotes the idea of lack of -- or non-movement  
20   so that the bones can naturally fuse together  
21   better?  
22 A   Absolutely. Yeah. So you want those two  
23   bones -- the C5 and C6 bones -- not to move, and  
24   then the healing will occur. Once it fuses, the  
25   body will use the fusion of bone to prevent any

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1   further movement, and then the plate actually  
2   just becomes superfluous at some point.  
3 Q   Did she tolerate the surgery okay?  
4 A   Yes.  
5 Q   And then I have the next note here, page 69 --  
6   do you see that? -- September 2 of 2020?  
7 A   Yes.  
8 Q   And this is a post-op visit, and I think on  
9   page 71 there is some comment that I would like  
10   for you to talk about. Yeah. It goes to the  
11   improvement noted by the patient at that time.  
12           Can you tell the Court here, based on  
13   this note and Ms. Gard's perception, what she  
14   felt -- how much she felt she improved from the  
15   surgery?  
16 A   Yeah. So at this point she says she's about  
17   20 percent better. You know, and we went  
18   through the questioning in every different way,  
19   and that was the number she came up with.  
20 Q   All right. One thing I skipped over, on page 67  
21   you talk about the risks of the surgery.  
22           What are the known, verifiable risk  
23   factors for the type of surgery Ms. Gard had?  
24 A   I mean, the risks are basically neurologic  
25   injury, injury to the nerves, to the spinal

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1 cord. There can be bleeding. There can be a  
2 spinal fluid leak. There can be injury to the  
3 soft tissue structures in the neck, that  
4 includes the vein, the artery that's there.  
5 There is other nerves in that area as well.  
6 There is the trachea, the esophagus, the  
7 thyroid. I mean, all these structures are right  
8 there, and certainly they're at risk for injury.

9 There can be a risk of bleeding after  
10 the surgery where you would have to go back in  
11 and remove the blood clot. And usually you see  
12 that within the first day -- day of the surgery.  
13 Infection certainly is a risk. There is a risk  
14 that she doesn't fuse, and the metal plate I put  
15 in can break. So these are the big risks  
16 specific to the surgery.

17 And then there is general risks. You  
18 know, she could have a heart attack. She could  
19 have a blood clot in the leg that can go to the  
20 lung. She can get pneumonia. You know, all  
21 these other general risks.

22 Q Is it also a risk of this surgery that it may  
23 not work to the patient's satisfaction, meaning  
24 the patient may not get the relief that he or  
25 she had hoped for?

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1 A That's always a risk. Absolutely. And I think  
2 that with every patient we're very clear on that  
3 and we just say, you know, we feel that  
4 statistically this is what should happen, but I  
5 said, you know, I can never guarantee it. And I  
6 think with Sheila, you know, as you can see, we  
7 took a slow train to surgery. You know, we  
8 never ever said to her, "You've got to choose  
9 now" or "Let's just jump to surgery." We  
10 purposely take a slow train because this is a  
11 very thoughtful process.

12 Q Those risk factors that we just described there  
13 in the past couple minutes, are those risk  
14 factors that were explained to Ms. Gard?

15 A Yes.

16 Q Prior to surgery?

17 A Yes.

18 Q All right. A couple things that I want to go  
19 over, Doctor. I talked about the physical  
20 therapy records, but I didn't give you a chance  
21 to go -- to look through those, and nor did I go  
22 over those in any great detail. I would like to  
23 turn your attention to Exhibit 5.

24 I don't want you to go through these,  
25 but if you could just generally breeze through

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1 these, do these appear to you to be physical  
2 therapy records pertaining to Ms. Gard from  
3 various Aurora facilities?

4 A Yes.

5 Q And, again, I'll represent to you this physical  
6 therapy time frame was from roughly April of  
7 2017 extending into early 2018.

8 With that representation, would that  
9 be a reasonable time period for Ms. Gard to  
10 undergo physical therapy?

11 A Absolutely.

12 Q The treatment that we have gone over today from  
13 the ER -- or excuse me -- the urgent care, the  
14 primary doctor, physical therapy, Dr. Ong, and  
15 then the visits with you, do you believe all of  
16 that treatment to be reasonable and necessary to  
17 address the injuries that Ms. Gard sustained in  
18 this March 24th of 2017 accident?

19 A Absolutely. It's -- it's the standard of care.

20 Q All right. Next I want to draw your attention  
21 to Exhibit 6.

22 Have you had a chance to review this  
23 document prior to today's deposition?

24 A Yes.

25 Q Before we get into that specifically, I want to

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1 get a little background.

2 You are a medical doctor, you are not  
3 necessarily a billing expert, you have people in  
4 your office to do that for you; is that correct?

5 A That is correct.

6 Q Are you generally aware of the various costs for  
7 various procedures that your patients undergo?

8 A In general, yeah. I mean, never the specific  
9 exact amounts, but I have a general idea.

10 Q All right. What I would like to do, then, is  
11 draw your attention to Exhibit 6, and I'll  
12 represent to you that this is a graph that my  
13 office made based upon the actual certified  
14 medical bills that will be part of Exhibit 2 at  
15 trial.

16 With that background and that  
17 representation, I would like to draw your  
18 attention to the left-hand column of this  
19 document. How this document works here, it's  
20 two pages, and the first column on the left-hand  
21 side of page one of Exhibit 6 then goes onto the  
22 second page of Exhibit 6, and it runs a total  
23 there.

24 Do you understand what I'm getting at  
25 Doctor?

<p style="text-align: right;">Page 38</p> <p>1 <b>A I do. I do.</b></p> <p>2 Q Okay. And I would like for you to just briefly</p> <p>3 look through those charges on the left-hand</p> <p>4 column there, both page one and two. It</p> <p>5 includes urgent care, facet joint prices,</p> <p>6 physical therapy, and some imaging.</p> <p>7 Do you see that, Doctor?</p> <p>8 <b>A I do.</b></p> <p>9 Q And the bottom the total there is \$80,878.92.</p> <p>10 Do you see that?</p> <p>11 <b>A I do.</b></p> <p>12 Q Do you agree that those are generally reasonable</p> <p>13 charges for those procedures, Doctor?</p> <p>14 <b>A Yeah. I mean, I realize that, you know, these</b></p> <p>15 <b>are large numbers, but that is in line with what</b></p> <p>16 <b>I've seen with -- from other centers, other</b></p> <p>17 <b>practices, so that's well within the normal</b></p> <p>18 <b>range.</b></p> <p>19 Q All right. The same questions I'm going to have</p> <p>20 with respect to a couple different graphs here.</p> <p>21 Do you see Wisconsin Radiology, do you</p> <p>22 see that segment there?</p> <p>23 <b>A I do.</b></p> <p>24 Q Do you see the Metropolitan Anesthesiologists?</p> <p>25 <b>A I do.</b></p>	<p style="text-align: right;">Page 40</p> <p>1 stay relative to the surgery you performed?</p> <p>2 <b>A I do.</b></p> <p>3 Q And the last topic of discussion with Exhibit 6</p> <p>4 here are your charges, and that's on the top</p> <p>5 right of page 1 of Exhibit 6. It details office</p> <p>6 visits and then eventually a surgeons' charge</p> <p>7 and then a couple more office visits.</p> <p>8 Do you see that?</p> <p>9 <b>A Yes, I do.</b></p> <p>10 Q And the total there is \$103,127.</p> <p>11 Do you see that?</p> <p>12 <b>A Yes.</b></p> <p>13 Q And do you believe your charges for the services</p> <p>14 you performed on Ms. Gard are reasonable in</p> <p>15 nature?</p> <p>16 <b>A I do.</b></p> <p>17 Q Okay. Doctor, you understand that various</p> <p>18 providers can charge various different price</p> <p>19 tags for the same surgeries?</p> <p>20 <b>A Yes.</b></p> <p>21 Q And is that, in fact, a common phenomenon to</p> <p>22 your knowledge, that various neurosurgeons in</p> <p>23 the community may charge different prices for</p> <p>24 same or similar services?</p> <p>25 <b>A Yeah. I mean, I think the neurosurgeons</b></p>
<p style="text-align: right;">Page 39</p> <p>1 Q Do you see the Columbia St. Mary's charges</p> <p>2 there?</p> <p>3 <b>A I do.</b></p> <p>4 Q I'm going to assume that Wisconsin Radiology and</p> <p>5 Metropolitan Anesthesiologists are various</p> <p>6 anesthesiology or radiology groups.</p> <p>7 Would you agree with that?</p> <p>8 <b>A Yes.</b></p> <p>9 Q And those charges seem to be about -- well,</p> <p>10 exactly \$76 and \$10,868.</p> <p>11 Do you see those numbers?</p> <p>12 <b>A I do.</b></p> <p>13 Q Do you agree that those are generally reasonable</p> <p>14 prices for those services?</p> <p>15 <b>A I agree.</b></p> <p>16 Q The Columbia St. Mary's, that indicates it's</p> <p>17 from the surgery and hospital stay. Those dates</p> <p>18 correlate with the dates we just talked about</p> <p>19 for the fusion surgery, so I'll call these the</p> <p>20 facility charge, and that facility charge is</p> <p>21 \$34,822.59.</p> <p>22 Do you see that?</p> <p>23 <b>A I do.</b></p> <p>24 Q Do you agree that that is a reasonable charge</p> <p>25 for the surgery facility charge and the hospital</p>	<p style="text-align: right;">Page 41</p> <p>1 <b>generally don't talk to each other about</b></p> <p>2 <b>pricing. I mean, to some degree we can't</b></p> <p>3 <b>because there would be a collusion issue. But I</b></p> <p>4 <b>think that everyone tries to charge what they</b></p> <p>5 <b>believe a fair price based on their practice</b></p> <p>6 <b>experience and the services they offer.</b></p> <p>7 MR. KNOBLOCH: Okay. At this point I</p> <p>8 would like to move into evidence Exhibit 3, 4,</p> <p>9 5, 6, 7, and 8.</p> <p>10 Any objection?</p> <p>11 MR. PAWLAK: Yeah. I would like to</p> <p>12 object until I have an opportunity to</p> <p>13 cross-examine him about these exhibits, and then</p> <p>14 we can take that up afterwards.</p> <p>15 MR. KNOBLOCH: Okay.</p> <p>16 BY MR. KNOBLOCH:</p> <p>17 Q Doctor, have all of your opinions today been to</p> <p>18 a reasonable degree of medical certainty?</p> <p>19 <b>A Yes.</b></p> <p>20 MR. KNOBLOCH: Subject to moving these</p> <p>21 into evidence, I have no further questions for</p> <p>22 this doctor.</p> <p>23 MR. PAWLAK: Thank you.</p> <p>24 EXAMINATION</p> <p>25</p>

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1 BY MR. PAWLAK:

2 Q Let's start with Exhibit 6, where we finished

3 off here. Can you tell us why under the

4 Metropolitan Anesthesiologists there are two

5 identical itemizations for \$5,434?

6 A I can't tell you that because I didn't generate

7 the bill.

8 Q Okay.

9 A Nor I did personally review the bill. All I

10 have is the number in front of me.

11 Q So really, although you testified you believe

12 these were reasonable, you really have a

13 complete lack of foundation here to comment

14 whether these are reasonable prices?

15 MR. KNOBLOCH: Objection to form.

16 THE WITNESS: I don't have a detailed

17 review of what the charges are. I know that

18 roughly in the market I think these are

19 approximately reasonable. If you said to me,

20 you know, "What is an anesthesiologist supposed

21 to charge?" I couldn't tell you, because I'm not

22 an anesthesiologist.

23 BY MR. PAWLAK:

24 Q Okay. Exactly. Well, as you're looking at this

25 from whatever -- whatever basis that you're

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1 making, you're offering this opinion, when does

2 the anesthesiologist -- at what point does the

3 anesthesiologist fee become unreasonable?

4 A I think you would have to ask an

5 anesthesiologist.

6 Q Okay. So then you would agree with me you

7 really have no basis to comment on whether or

8 not this anesthesiologist fee was reasonable?

9 MR. KNOBLOCH: Objection to form.

10 THE WITNESS: I think my basis is on,

11 you know, approximately, it's a physician

12 providing a service for X amount of period of

13 time. You know, it's an approximate number, I

14 could say that it's reasonable.

15 Because if you said to me, "What are

16 they doing?" you know, I would say, "Yeah,

17 they're keeping the patient alive, they're --

18 they're accepting a risk." I mean, there is a

19 lot of time investment, and they have to do

20 postoperative care. I think that if you said to

21 me, you know, given the fact that in medicine

22 what we charge, you know, they're going to

23 change about this number, I would say relative

24 to everyone else, that seems reasonable.

25 Now, we have to also remember, you

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1 know, a lot of the charged amounts that are

2 submitted to insurance companies, we don't get

3 paid this. So, you know, there is charged --

4 there is billed amounts, and then there is

5 whatever you get billed. And so, you know,

6 these numbers are generated by all practices.

7 Everyone has their way of developing their

8 numbers, and I'm telling you, relative to all

9 other charges, I would say this is reasonable.

10 BY MR. PAWLAK:

11 Q Okay. So before we get to how you generate your

12 numbers -- that's a great segue -- let me go

13 back to one more point.

14 So, for example, here, the hospital

15 stay is at 34,822. You've testified that you

16 believe that was reasonable; is that correct?

17 A Correct.

18 Q What are you basing that upon?

19 A Again, based on what I've heard other facilities

20 charge. You know, I've seen facilities charge

21 more than this, and so to me that seemed a

22 reasonable number. I mean, I wouldn't have been

23 shocked -- shocked. I've seen Aurora charge

24 double this.

25 Q Okay. So at what point would you be shocked?

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1 100,000? 150? A quarter million? What would

2 be unreasonable in your opinion, based upon your

3 knowledge and experience in this area?

4 A I mean, I think that, you know, certainly if

5 they got to a number that was significantly

6 higher, so maybe over 100,000.

7 Q Okay. So how do you set your fees?

8 A So our fees were set many, many years ago by my

9 billing manager. So 20 years ago we started the

10 practice and it was part of a larger group of

11 neurosurgeons and they had their fees, and we

12 really couldn't share fee numbers. We were

13 told, you know, "You have to set your fees."

14 So I had a billing manager start, and

15 she -- she checked national fee numbers, and

16 then she set my fees. And then every year --

17 and this was 20 years ago, this is 2001, 2002,

18 2003, roughly in there -- she gradually

19 increased the fees based upon what insurance

20 companies allowed, based upon national trends,

21 based on inflation.

22 And just over the years she has, you

23 know, roughly increased the fees, and she would

24 say, "Hey, you know, Dr. Dagam, you've had the

25 same fees for the last three years. You know, I



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1 think it's time we increase the fees a certain  
 2 percentage," and I said, "Okay."  
 3 And she goes, "You know, I think, you  
 4 know, the other neurosurgeons are increasing  
 5 their fees, I've talked to other doctors," so  
 6 she has increased the fees over 20 years, and  
 7 this is kind of where we ended up.  
 8 I would say if -- you know, my fee  
 9 numbers are based upon 20 years of practice, 20  
 10 years of experience, and the complexity of what  
 11 we do. We do complex spine cases. Spine cases  
 12 do generally charge more than other surgical  
 13 cases. Spine cases, they generate -- they have  
 14 higher RVU numbers. When you add them all up,  
 15 the RVU numbers are much larger.  
 16 So if you base it on -- per -- you  
 17 know, on the number of RV -- total RVUs, you  
 18 know, we're going to have a larger bill. We've  
 19 been around for 20 years. We have 20 years of  
 20 experience. So I think all that kind of comes  
 21 together. That's how we have generated our  
 22 charges.  
 23 Q Please define what RVU is.  
 24 A Relative value unit. Again, I'm not a billing  
 25 expert, but that's -- that's sort of the

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1 assigned value for any particular procedure you  
 2 do. So doing a cervical fusion, each different  
 3 part of the fusion has a value, a relative  
 4 value. And so we're doing, like, at least -- if  
 5 you look at the op. note, we're doing at least  
 6 three or four different things.  
 7 And I think -- and I don't know if  
 8 this fee also includes the assistant fee. I  
 9 don't know. I don't know if that includes that.  
 10 Q Just to give you a preview, I will be addressing  
 11 that issue, but I'm going to stick with this one  
 12 for the time being.  
 13 So what's your billing manager's name,  
 14 please?  
 15 A So my billing manager has changed. We've  
 16 changed this year because of COVID. So it was  
 17 originally Heidi Weber, but now it's  
 18 Rhonda Nessler.  
 19 Q So is Heidi no longer working for you?  
 20 A No. Because of COVID, our practice reduced, and  
 21 she wanted a bigger position, so she moved on.  
 22 Q So are you aware of where you are for charging  
 23 for spine-type surgeries within the Milwaukee  
 24 area? Are you high? You're low? You're in  
 25 between?

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1 A I don't know because I don't ask other surgeons  
 2 what their numbers are.  
 3 Q Okay. And have you ever heard, for example, of  
 4 charging -- so, for example, you know, 110 or  
 5 120 percent of what Medicare would pay for a  
 6 similar surgery?  
 7 A Could you repeat that.  
 8 Q Sure. Sure. You must be aware that Medicare  
 9 sets prices, reimbursement rates for surgery;  
 10 correct?  
 11 A Correct.  
 12 Q And I'm sure you've done similar surgeries here  
 13 today for Medicare?  
 14 A Correct.  
 15 Q And they usually -- I know doctors complain  
 16 about what Medicare pays?  
 17 A Yes.  
 18 Q All right. So if you were -- have you ever  
 19 heard in private practice, capitalism rules in  
 20 this country, we control what we want to charge  
 21 for ourselves?  
 22 A Yes.  
 23 Q Have you ever heard of doctors setting -- for  
 24 example, "I know what Medicare pays for this  
 25 surgery, I'm going to charge 125 or 150 percent

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1 of what Medicare pays"? Have you ever done  
 2 anything like that to your knowledge?  
 3 A I think, yes, to some degree I have heard that,  
 4 where doctors will charge a multiple of what  
 5 Medicare will pay. So it's not typically 1.2,  
 6 1.3, but it will typically be 2 to 3 times or  
 7 even higher than that.  
 8 Q Okay.  
 9 A And that's what their -- and that would be what  
 10 their billed amount is. So, again, our billed  
 11 amounts are very different than what we get  
 12 paid, you know, because if we submit a bill --  
 13 we'll submit the same charge to Medicare, but  
 14 we'll just get Medicare reimbursement numbers,  
 15 you know, et cetera.  
 16 Q Do you know whether you've been paid anything  
 17 for these surgeries?  
 18 A I would have to ask my billers, because I don't  
 19 know if I've been paid for this or not.  
 20 Q Okay. All right. So you don't know if your  
 21 surgery is -- your prices that you charge are  
 22 high/low for what you do, it's just based upon  
 23 20 years of cumulative surgery and your --  
 24 Heidi Weber adjusting the rates over those --  
 25 A Correct.

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1 Q -- 20 years?

2 A **Correct.**

3 Q Okay. All right. I'm going to give you what's

4 been marked as Exhibit No. 9. It's described as

5 a Patient History Detail for the neurological

6 surgery that you did in this matter.

7 So Plaintiff's attorney submitted a

8 document, Exhibit 6, which indicates your fees

9 were 103,127. The document which I have in

10 front of you, which is broken down into

11 significant detail, indicates it's 101,527, so

12 relatively close in the grand scheme of things;

13 correct?

14 A **Correct.**

15 Q All right. So you indicated earlier, you asked

16 whether or not the fees reflected in Exhibit 6

17 actually detailed the work done -- I think you

18 used the word "assistant" in the surgery

19 process?

20 A **Yes.**

21 Q And who was that assistant, and who is that

22 person?

23 A **Oh, yeah. So my physician assistant,**

24 **Beau Boedecker.**

25 Q So on this sheet there is obviously

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1 abbreviations used, and there is a provider

2 column, it's P-R-O-V.

3 And you would agree that stands for

4 "provider"; right?

5 A **Correct.**

6 Q And there are names listed. Your name, of

7 course, is in full, D-A-G-A-M, which is your

8 entire last name.

9 And then there is B-E-A-U-B, and whom

10 does that remember to?

11 A **That refers to the physician assistant,**

12 **Beau Boedecker.**

13 Q All right. And then we have on the far left

14 side here the codes for the surgical procedures;

15 is that correct?

16 A **Correct. Yes.**

17 Q And this is -- this is how typically billing

18 works in America today. Every process you

19 perform has to have a code assigned to it, and

20 then you bill out for that?

21 A **That is correct.**

22 Q So, for example, although we've been referring

23 to this as one surgery, this thing is broken

24 down here into at least 17, 18-plus different

25 components of that surgery that you performed

Page 52

1 that day?

2 A **I don't know the exact number, but it is broken**

3 **down into many components.**

4 Q Yeah. I mean -- and if you don't want to trust

5 my counting, feel free to count on your own. I

6 mean, I'm just trying to hit the ballpark here.

7 A **Sure. Sure. I know it's a multiple. Yes.**

8 Q All right. So -- and each of these codes -- for

9 example, let's look at the first code, 63081.

10 Are you familiar with that?

11 A **Yes.**

12 Q And what is that, if we can refer to it as one

13 or two words to give it a --

14 A **Yeah.**

15 Q -- title?

16 A **Yeah. It's called a corpectomy code.**

17 Q Okay. So I looked through your report, and I

18 never found a mention of a corpectomy.

19 Why is that?

20 A **I don't know if the -- are you talking about the**

21 **operative report?**

22 Q Yeah. Yeah.

23 A **I don't know where -- do you have a copy of it?**

24 Q Well, I'll tell you what. I'm going to pull

25 open -- we're still on the record here. I want

Page 53

1 to just, if you don't mind -- you -- let me do a

2 little segue.

3 You previously testified in a

4 deposition conducted by me; is that correct?

5 A **I believe so.**

6 Q Yes. And I have here the certified original

7 copy of that, which is still in the plastic, and

8 I'm going to open here today to use again so we

9 don't duplicate this multiple times.

10 A **Sorry. I was going through the wrong stack.**

11 Q So I'm going to give to you what was previously

12 marked as Exhibit No. 1 -- this might be -- in

13 that deposition which was conducted on

14 October 13, 2021, here at your same office of

15 which we were present today. The -- your

16 operative reports are in that exhibit pages 67

17 through 79.

18 Feel free to go to those pages and

19 tell me if you mention anything called a

20 corpectomy in there.

21 A **Yeah. So I actually use the word**

22 **"vertebrectomy," and that's basically the same**

23 **thing.**

24 Q Okay. Is there any difference between a

25 corpectomy and a vertebrectomy whatsoever?

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1 **A In my -- for me, no.**  
 2 **Q** Okay. Would there be some other practitioners  
 3 who might have a nuance on those meanings?  
 4 **A There may be, but I don't know what that**  
 5 **different would be.**  
 6 **Q** Okay. So you talk about the partial C5  
 7 vertebrectomy and partial C6 vertebrectomy; is  
 8 that correct?  
 9 **A Correct.**  
 10 **Q** Now, why was it important to note that the  
 11 partial C5 was a decompression of the spinal  
 12 cord of 55 percent and the partial C6  
 13 vertebrectomy -- vertebrectomy -- excuse me --  
 14 was a decompression of the spinal cord of  
 15 60 percent? What's the relevance and importance  
 16 of those points?  
 17 **A Yeah. So that kind of goes back to my billing**  
 18 **manager. So when we were doing these reports,**  
 19 **she has said to me, "Be as detailed and specific**  
 20 **as you can." So it's not necessarily critical**  
 21 **in this particular case, and it doesn't have**  
 22 **necessarily a critical clinical application. It**  
 23 **was more of a billing person.**  
 24 **Because what my billing manager would**  
 25 **do is with other insurance companies they would**

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1 **often just not want to pay any codes, and then**  
 2 **she would go back and say, "Well, Dr. Dagam very**  
 3 **clearly specified in this operative report."**  
 4 **So she -- she had a long conversation**  
 5 **with me one time. This was many years ago. She**  
 6 **said, "You know, the more detailed you are" --**  
 7 **because originally when doctors do operative**  
 8 **reports, we're kind of going through them**  
 9 **quickly, you know. I mean, if it was up to me,**  
 10 **this operative report would be, like, four**  
 11 **sentences. You know, I just -- I would**  
 12 **literally just give a very general description,**  
 13 **and then obviously, you know, if anything -- any**  
 14 **complication occurred, I would put that in**  
 15 **there.**  
 16 **But with her, she said, "Look, you**  
 17 **know, my job is hard enough, so I need you to be**  
 18 **crazy detailed," so that -- that was the reason**  
 19 **why we kind of go into that level of detail.**  
 20 **Q** Are you aware that, in fact, if the -- if the  
 21 decompression of the spinal cord is less than  
 22 50 percent, you can't charge as much?  
 23 **A I don't know if that's the case, but she told**  
 24 **me, "If you're going to do a partial, you know,**  
 25 **don't" -- I don't know, she gave me some**

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1 **guidelines on it, so I said, "All right, well,"**  
 2 **I go, "I'm not going to say anything that**  
 3 **obviously I didn't do," and she goes, "Yeah,**  
 4 **absolutely not."**  
 5 **So when we go in there, we do what's**  
 6 **necessary and then we dictate it. You know, so**  
 7 **if we're taking out 50 percent, you know, we're**  
 8 **like, all right, well, you know, she says, you**  
 9 **know, just make it 51 percent, just go in there,**  
 10 **and so I -- I kind of had to do what was**  
 11 **necessary and then make this report have enough**  
 12 **detail for her to be able to use it as whatever**  
 13 **she needed to fight the insurance company on.**  
 14 **Q** Is it also true that one of the nuances in the  
 15 distinction or the definition between corpectomy  
 16 and vertebrectomy is a corpectomy is over  
 17 50 percent --  
 18 **A I don't --**  
 19 **Q -- by definition?**  
 20 **A Yeah, that I don't know. Yeah. To me**  
 21 **vertebrectomy and corpectomy are very much the**  
 22 **same.**  
 23 **Q** So 63081 is we'll call it the corpectomy. And  
 24 what is your assistant's name again, please?  
 25 **A Beau Boedecker.**

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1 **Q** Beau Boedecker. His charge amount for that was  
 2 \$7,365; is that accurate?  
 3 **A Yes.**  
 4 **Q** And then we go down to the second cor- -- help  
 5 me with this, please -- corpectomy?  
 6 **A Correct.**  
 7 **Q** And that was performed by you; correct?  
 8 **A Correct.**  
 9 **Q** And you charged \$20,251 for that?  
 10 **A Correct.**  
 11 **Q** Are you three times better than he is? Three  
 12 times faster? What's the difference for the  
 13 prices?  
 14 **A Well, we work together.**  
 15 **Q** Okay.  
 16 **A Yeah. So he -- he's assisting me under the**  
 17 **microscope. I'm working there. We're both**  
 18 **working together. And so I -- you know, we have**  
 19 **to do the corpectomy together.**  
 20 **Q** Okay. So correct me if I'm wrong, but I  
 21 envision you being the -- since you're the  
 22 surgeon, I envision you doing all the cutting  
 23 and the placing, and he's helping you out and  
 24 assisting you in whatever way, shape, and form  
 25 that you would deem necessary; correct?

<p style="text-align: right;">Page 58</p> <p>1 A That's correct.</p> <p>2 Q So why do we split up this billing on the sheet?</p> <p>3 Why is this done? What's the story behind this?</p> <p>4 A Well --</p> <p>5 Q It looks as if he performed one set of the stuff</p> <p>6 and you performed the other?</p> <p>7 A I think this is billing convention. So I don't</p> <p>8 set billing convention. I didn't invent it, nor</p> <p>9 do I enforce it. This is billing convention.</p> <p>10 This is the way billing is done.</p> <p>11 If it was personally up to me, you</p> <p>12 know, I would say "This is what we did, pay me</p> <p>13 this amount," but this is how the system is set</p> <p>14 up, so that's why it's split up into all these</p> <p>15 different categories and there is charges for</p> <p>16 him, charges for me.</p> <p>17 Q Okay. Let me get back to that. So describe to</p> <p>18 me literally what mechanically goes on. I know</p> <p>19 you did it earlier. But for the corpectomy,</p> <p>20 what qualifies, what procedure, what did you do</p> <p>21 to be able -- entitled you folks to bill under</p> <p>22 63081 for the corpectomy?</p> <p>23 A Well, we go in, we identify the disc space,</p> <p>24 remove the disc material. We feel underneath</p> <p>25 the vertebral bone. We feel that it's a little</p>	<p style="text-align: right;">Page 60</p> <p>1 they're not familiar with the surgery, it's --</p> <p>2 they're useless, you know.</p> <p>3 So a brand new PA from PA school is no</p> <p>4 good. Beau, who has been in with -- who has</p> <p>5 been with me for, you know, hundreds of cases,</p> <p>6 hundreds, maybe thousands of cases, that's</p> <p>7 critical. His skill is critical. So, you know,</p> <p>8 maybe the numbers reflect that, you know, that</p> <p>9 experience, that information, the nuance.</p> <p>10 You know, it's kind of like having</p> <p>11 someone who really has played the violin really</p> <p>12 well as a first and second violin, and together</p> <p>13 you have a symphony. And I'm not a musician, so</p> <p>14 I'm just -- my metaphor might be horrible, but</p> <p>15 that's literally what's happening.</p> <p>16 Q Okay. Let's move on to the next one. 63082, do</p> <p>17 you know what that one is?</p> <p>18 A That's the other vertebrectomy code for the</p> <p>19 other, the C6.</p> <p>20 Q And can we assign a brief descriptor to that</p> <p>21 process?</p> <p>22 A Same thing that happens to the C6 side, the</p> <p>23 other side of the disc space.</p> <p>24 Q All right. Well, for example -- and you can</p> <p>25 correct me if I'm wrong, but 63081, there is one</p>
<p style="text-align: right;">Page 59</p> <p>1 tight, so we want to start taking out bone. And</p> <p>2 in order to get that, we sometimes have to shave</p> <p>3 down from the top down. We do that. We take</p> <p>4 additional bone.</p> <p>5 We have to even out the surfaces, so</p> <p>6 you have to remove additional bone for that. So</p> <p>7 there is a lot of shaping of the -- of the C5</p> <p>8 and C6 vertebral bodies, one, to remove</p> <p>9 ligament, to remove any osteophytes, and to make</p> <p>10 it all even. Because if it's not even, then you</p> <p>11 can't put the fusion device inside it to get it</p> <p>12 to heal. So there is a lot of work to be done.</p> <p>13 There is continuous bleeding, so the</p> <p>14 assistant is there to help suction any bleeding.</p> <p>15 He's there to help me hold tissue back. Because</p> <p>16 when he has to retract the esophagus and trachea</p> <p>17 in order for me to work, he's looking through</p> <p>18 there, he's identifying any additional bleeders</p> <p>19 that I may not see. He's suctioning.</p> <p>20 So it's a symphony of two people</p> <p>21 working together. I can't do this case by</p> <p>22 myself. It's very difficult. And so without</p> <p>23 the -- without a highly skilled assistant --</p> <p>24 because I can bring in an assistant, and if they</p> <p>25 don't have knowledge, if they're not skilled, if</p>	<p style="text-align: right;">Page 61</p> <p>1 on top, and then there is one below --</p> <p>2 A Correct.</p> <p>3 Q -- for you, so -- and we said those were the</p> <p>4 corpectomies, one for the C5 and one for the C6;</p> <p>5 is that right?</p> <p>6 A Well, 63081 is for the C5.</p> <p>7 Q Okay.</p> <p>8 A And then 63082 is for the C6.</p> <p>9 Q All right. So what's the second 606301 [sic]</p> <p>10 down below for?</p> <p>11 A You're talking about why are there two 63081s</p> <p>12 and --</p> <p>13 Q Correct.</p> <p>14 A Well, there is one 63081 for Beau.</p> <p>15 Q Yes.</p> <p>16 A And one for me.</p> <p>17 Q Ah, but they include both C5s?</p> <p>18 A Well, remember, I said that we both work</p> <p>19 together.</p> <p>20 Q You both work together. Fine.</p> <p>21 A And convention -- so I, again, did not invent</p> <p>22 billing convention, you're asking me</p> <p>23 questions --</p> <p>24 Q Yeah.</p> <p>25 A -- that really I am not the expert on.</p>



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1 Q Yeah.

2 A **The way it works is he and I both do the**

3 **corpectomy.**

4 Q Correct. I've got that. I understand that.

5 A **And because we both work together, there is a**

6 **bill for him, and there is a bill for me.**

7 Q Okay. But 63082 is an entirely different code.

8 Why would you use a different code for the same

9 surgery, same -- one is a C5 and one is a C6,

10 doesn't it make more sense that the 63081 down

11 below is for the C6, for example?

12 A **No. Because the coding -- again, not my policy,**

13 **but the coding rules require that the other**

14 **vertebral body get -- gets its own code and it's**

15 **a different code and it's called the additional**

16 **corpectomy code.**

17 Q Okay. But I thought 63082 was for

18 decompression. No?

19 A **It -- yeah. It's for the corpectomy.**

20 **Vertebrectomy and decompression of the cord.**

21 **Yes.**

22 Q Okay. So what I'm suggesting to you is that

23 there is a series of numbers at the top of the

24 different codes that were done for C5, and then

25 we start again under your name, for example, for

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1 C6 with --

2 A **No.**

3 Q You don't see it that way?

4 A **No.**

5 Q Okay.

6 A **And I think that maybe you're misinterpreting,**

7 **and I don't know.**

8 Q Well, that's what we're here to find out.

9 A **So there is a set of codes for Beau, and so**

10 **there is a 63081, 82, 22 -- I mean, a bunch of**

11 **codes for Beau.**

12 Q Yes.

13 A **And then there is a bunch of codes for me.**

14 Q Correct.

15 A **And since he and I are both working together, we**

16 **are required to bill each code to each provider,**

17 **so you don't just -- so, I mean, if we're both**

18 **working on the corpectomy, we have to bill each**

19 **of us -- each of us separately.**

20 Q Okay. So there is no breakdown, then, on this

21 sheet for C5 and C6?

22 A **Well, I think there is a breakdown because to**

23 **me, you know, it doesn't -- it depends on which**

24 **one you assign to which --**

25 Q Yeah.

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1 A **-- vertebral body. It doesn't say that 63081 is**

2 **C5 --**

3 Q No.

4 A **-- or 63082 is C6. It doesn't say that. It**

5 **just says that that's one corpectomy, and then**

6 **the other one is the additional. And it really**

7 **just depends on how you read the operative**

8 **report.**

9 Q So this is the question:

10 Are we breaking down this surgical

11 procedure by C5 and C6, or are we breaking it

12 down by provider, in this case by you and your

13 assistant, Beau?

14 A **I think -- I think you have to do both. I mean,**

15 **I think that's -- again, that's the convention.**

16 **We -- we are -- you know, we are not given a**

17 **choice on how to bill this. This is the way**

18 **billing is done.**

19 Q All right. So what is 2251 [sic], then, what --

20 what -- what part of this entire process is

21 that?

22 A **That is the arthrodesis, which is basically**

23 **getting the surface of the vertebral bodies**

24 **prepared for the fusion so that you can put a**

25 **spacer in there. So that means evening it out,**

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1 **taking -- making sure if there is any excess**

2 **bleeding, that's taken care of. I mean, all**

3 **those little things we have to do.**

4 Q Okay. And that's commonly referred to as a

5 fusion, perhaps?

6 A **It could be.**

7 Q Arthrodesis?

8 A **It could be. Yeah. Arthrodesis is just the**

9 **medical term.**

10 Q Okay. And he charged 7,500, and you charged

11 20,625; is that correct?

12 A **That is correct.**

13 Q All right. And then 22853, do you know what

14 that is?

15 A **That's the -- getting the vertebral spacer**

16 **ready.**

17 Q Is that also referred to as the cage?

18 A **Yes.**

19 Q Describe that again, please.

20 A **So we get a cage -- well, first we have to**

21 **measure the size of the cage. We do trials. We**

22 **get the cage. We fill it with bone from the**

23 **patient, put cadaver bone in there. We put it**

24 **into the -- we put it into the spacer, make sure**

25 **it's large enough, but not too large. We tap it**

<p>Page 66</p> <p>1 in and then make sure it's countersunk</p> <p>2 appropriately.</p> <p>3 Q And his charge for that was 1,770, and your</p> <p>4 charge was 4,866; is that correct?</p> <p>5 A That is correct.</p> <p>6 Q And then we have 22845, do you remember what</p> <p>7 that is?</p> <p>8 A Yeah. That's putting in the cervical plate.</p> <p>9 Q And what is the plate, again, please?</p> <p>10 A The plate is a titanium plate that we put on the</p> <p>11 surface of the C5 and C6, put screws in and</p> <p>12 anchor it to the bone.</p> <p>13 Q And he charged \$3,826 for that, and you charged</p> <p>14 \$10,519 for that; is that correct?</p> <p>15 A That is correct.</p> <p>16 Q And there is a number of other codes in here,</p> <p>17 but there is only one of those. For example,</p> <p>18 61783, do you know what that is for?</p> <p>19 A Let me see here. Yeah. That's for -- so we</p> <p>20 spent time with preoperative planning, so</p> <p>21 that -- we can charge for that. And then we</p> <p>22 used some navigation, so we just took some</p> <p>23 X-rays and then we put it into a navigation</p> <p>24 system just to make sure our screws and our</p> <p>25 plate were as even as possible.</p>	<p>Page 68</p> <p>1 area?</p> <p>2 A I don't do that, I haven't looked at it, so I</p> <p>3 wouldn't be shocked or surprised. I -- you</p> <p>4 know, I just don't do that.</p> <p>5 Q Well, I'm going to hand you Exhibit No. 10, and</p> <p>6 Exhibit No. 10 is for code 63082, which I call</p> <p>7 the decompression. And it says the average cost</p> <p>8 for that procedure in the United States is</p> <p>9 around 1,300, and you charge 9,200 averagely,</p> <p>10 but -- which is less than what you charged in</p> <p>11 this case.</p> <p>12 A Okay.</p> <p>13 Q Is that surprising to you?</p> <p>14 A I -- I don't know anything about this service,</p> <p>15 and I don't know how accurate they are, so I --</p> <p>16 I mean, thank you for this piece of paper, but I</p> <p>17 really don't put a lot of faith in it.</p> <p>18 Q Okay. Well, it's pretty accurate to you; isn't</p> <p>19 it? It lists pretty close to what you charged</p> <p>20 for this, although it's under, they were</p> <p>21 conservative here, you charged more than this in</p> <p>22 this particular procedure?</p> <p>23 A And I don't know how they get their numbers.</p> <p>24 Q Yeah. All right. And Beau -- Beau Boedecker's</p> <p>25 name is listed here and he's your assistant from</p>
<p>Page 67</p> <p>1 Q Is that the so-called Stealth system?</p> <p>2 A Yes.</p> <p>3 Q And then 77003?</p> <p>4 A That's for taking X-rays and interpreting the</p> <p>5 X-rays and so forth.</p> <p>6 Q That's the fluoroscope?</p> <p>7 A Yes.</p> <p>8 Q And that was a charge of \$987?</p> <p>9 A Yes.</p> <p>10 Q And, lastly, 69990?</p> <p>11 A Yes.</p> <p>12 Q That is for the --</p> <p>13 A Use of operating microscope.</p> <p>14 Q All right. And there is one fee for that for</p> <p>15 \$3,420; is that correct?</p> <p>16 A That is correct.</p> <p>17 Q All right. So I'm going to hand you what's been</p> <p>18 marked as Exhibit No. 10.</p> <p>19 Have you ever heard of consumer --</p> <p>20 internet consumer services where you can check</p> <p>21 out what your doctor is going to charge you for</p> <p>22 a service?</p> <p>23 A No, I've never heard of that.</p> <p>24 Q So you would be surprised to find out where your</p> <p>25 price range is for services in the Milwaukee</p>	<p>Page 69</p> <p>1 this case and he's about a third of what your</p> <p>2 rate is; is that correct?</p> <p>3 A Again, I don't know how it gets their numbers,</p> <p>4 and I'd have -- and I would have to do my own</p> <p>5 analysis to tell you --</p> <p>6 Q Yeah.</p> <p>7 A -- what our averages are.</p> <p>8 Q Okay.</p> <p>9 A So, I mean, again, thank you for this piece of</p> <p>10 paper, but --</p> <p>11 Q Sure.</p> <p>12 A -- again, I don't know how much weight I can put</p> <p>13 on this.</p> <p>14 Q All right. I'm going to hand you what's marked</p> <p>15 as Exhibit No. 11, and 11 is for the 63081, the</p> <p>16 vertebrectomy or the corpectomy. And that --</p> <p>17 once again, that lists your rate at 18,400, and</p> <p>18 the average for this surgery is 5,491.</p> <p>19 Is that surprising to you, that you're</p> <p>20 over three times higher than the average?</p> <p>21 A Again, I don't know what their numbers are.</p> <p>22 And, again, you know -- again, I don't know if</p> <p>23 that's the average for neurosurgeons with 20</p> <p>24 years' experience. Is that the average, you</p> <p>25 know -- you know, we're -- who's in this</p>

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1 average? You know, is it a -- is it a  
 2 neurosurgeon in XYZ city who just started out?  
 3 You know, I mean, we don't know what these  
 4 numbers are.  
 5 You know, so I -- I think that  
 6 absolutely there is going to be variation.  
 7 Absolutely. But, you know what -- you know,  
 8 there is going to be variation in car prices.  
 9 There is variation in hotel prices. There is  
 10 variation in airline prices. So absolutely  
 11 there is going to be variation.  
 12 Q Lastly, I'm going to hand you what's been marked  
 13 as Exhibit No. 12. That is the -- for the  
 14 fusion, 22551 code. And there your price is  
 15 listed at 18,750, with the average cost being  
 16 about 5,500 in the United States.  
 17 Once again, I assume you would testify  
 18 just as you did the previous two that --  
 19 A Yeah. Basically I don't know how -- how much --  
 20 how value this has -- how much value this has.  
 21 Q But this -- the price that's in here for all  
 22 three of these is actually less than what you  
 23 charged in the incident matter?  
 24 A The price is this is --  
 25 Q Yes.

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1 A -- less than what we charge --  
 2 Q In Exhibits 10, 11, and 12, the price they have  
 3 for you, the average price, is less than what  
 4 you charged in the incident matter here today?  
 5 A Yeah. But you don't know how they even come up  
 6 with any of these numbers, you know. Is it from  
 7 the year 2010? Is it from the year 2019? We  
 8 don't know. So, I mean, it's great to print  
 9 this from the internet. I -- I'm impressed that  
 10 you're able to find it, but to me it has no  
 11 value.  
 12 Q Well, thank you for the compliment, and I  
 13 appreciate your opinion.  
 14 So going to -- back to the surgery in  
 15 this question. You're a member of the North  
 16 American Spine Society?  
 17 A I used to be. I stopped going to the meetings.  
 18 I just didn't have time.  
 19 Q Okay. And tell us what that organization is.  
 20 A I think it's just an organization of spine  
 21 surgeons throughout the country.  
 22 Q Okay. And what -- do you find any value? Do  
 23 you attend their training seminars?  
 24 A I haven't gone because our surgeries -- I mean,  
 25 we do cutting-edge surgeries, and I'm kind of at

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1 the point now where what I do doesn't  
 2 necessarily get trained at their seminars,  
 3 because you really can't learn from a two-day  
 4 seminar how to do something very complicated,  
 5 you know. And I used to go to these things a  
 6 lot, and there is -- it's really just a taste of  
 7 something. It doesn't really teach you  
 8 anything.  
 9 So, you know, there wasn't a ton of  
 10 value to go to that, so I pretty much keep my  
 11 meetings to the American -- AANS, American  
 12 Association of Neurological Surgeons. It's  
 13 broader. It gives me both cranial and spine and  
 14 peripheral nerve --  
 15 Q Okay.  
 16 A -- education.  
 17 Q Were you aware that the North American Spine  
 18 Society publishes appropriate use criteria for  
 19 the surgery that you performed on Ms. Gard here?  
 20 A I'm sure that they do.  
 21 Q You've heard of -- so it's called a checklist,  
 22 that one should go and look through that  
 23 checklist to see what -- for example, what the  
 24 patient is exhibiting which could be objectively  
 25 seen as necessitating the need for the surgery?

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1 A Sure. Sure.  
 2 Q Okay. And did you do that in this incident  
 3 case?  
 4 A No, I didn't go through the checklist --  
 5 Q Okay.  
 6 A -- because a checklist doesn't always -- if you  
 7 don't know what you're doing, then go to a  
 8 checklist. You know, get a page out of a  
 9 textbook, read it through, and then follow the  
 10 recipe, you know. You know, if you're a  
 11 Michelin star -- star chef -- and I'm not saying  
 12 I'm a Michelin star neurosurgeon -- you know,  
 13 they don't go to a recipe -- Julia Child's  
 14 cookbook and say "How I do make XYZ?" You know,  
 15 a lot of the stuff we do, you know, we use  
 16 standard of care and common sense.  
 17 Q But where does the standard of care come from?  
 18 A Standard of care comes from talking to other  
 19 neurosurgeons, from our meetings, textbooks, so  
 20 forth, and cumulative experience.  
 21 Q So in this particular case, as I understand your  
 22 testimony, the only proffered reason for this  
 23 surgery was the subjective pain which Ms. Gard  
 24 was suffering?  
 25 A Correct.

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<p>1 Q So --</p> <p>2 A <b>And there was some abnormalities on the imaging,</b></p> <p>3 <b>too.</b></p> <p>4 Q Okay. And so just let me -- let me run down</p> <p>5 this checklist.</p> <p>6 So there was no neurological deficit?</p> <p>7 A <b>No.</b></p> <p>8 Q No indication of instability?</p> <p>9 A <b>No.</b></p> <p>10 Q No persistent loss of feeling, weakness, or</p> <p>11 muscle control?</p> <p>12 A <b>No.</b></p> <p>13 Q No evidence of nerve compression?</p> <p>14 A <b>No.</b></p> <p>15 Q No radicular pain?</p> <p>16 A <b>No.</b></p> <p>17 Q No neck pain causing weakness or pain in the</p> <p>18 arms?</p> <p>19 A <b>No.</b></p> <p>20 Q No numbness -- no numbness, tingling, or</p> <p>21 weakness?</p> <p>22 A <b>No.</b></p> <p>23 Q All right. So you did not have occasion to meet</p> <p>24 with Ms. Gard to a significant period -- excuse</p> <p>25 me -- a significant period after the motor</p>	<p>1 <b>that her pain improved when he treated those</b></p> <p>2 <b>levels.</b></p> <p>3 Q Okay. So that tells us where the pain is coming</p> <p>4 from. What is there out there that tells us</p> <p>5 this pain was caused by the motor vehicle</p> <p>6 accident?</p> <p>7 A <b>You know, I guess that's a great question. So I</b></p> <p>8 <b>think you can't say based on that data that it</b></p> <p>9 <b>was intrinsically for sure caused by the motor</b></p> <p>10 <b>vehicle accident, because there is nothing on</b></p> <p>11 <b>the imaging that has a little sign with an arrow</b></p> <p>12 <b>pointing saying "Caused by the MVA." However,</b></p> <p>13 <b>we never have that. We rarely do.</b></p> <p>14 <b>So all we have is history, and history</b></p> <p>15 <b>of pain, both what she had before and after the</b></p> <p>16 <b>accident, and the imaging, and so we have to put</b></p> <p>17 <b>all that together. And so basically the</b></p> <p>18 <b>narrative is that, you know, she didn't have the</b></p> <p>19 <b>neck pain before the accident, she has it</b></p> <p>20 <b>afterwards.</b></p> <p>21 <b>We -- certainly she goes through the</b></p> <p>22 <b>entire gamut of non-surgical treatment, and</b></p> <p>23 <b>really I think she wasn't looking for surgery,</b></p> <p>24 <b>you know, and I wasn't looking to do surgery on</b></p> <p>25 <b>her, as evidenced by our initial meetings. That</b></p>
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<p>1 vehicle accident?</p> <p>2 A <b>Can you be more specific with that question.</b></p> <p>3 Q Yeah. For example, she didn't see you within</p> <p>4 the week or a month after the accident; fair?</p> <p>5 A <b>No. No, she did not.</b></p> <p>6 Q There was a significant period of time that</p> <p>7 elapsed in the chronological history before she</p> <p>8 had an opportunity to see you after the</p> <p>9 accident, she was referred to you by other</p> <p>10 doctors; is that correct?</p> <p>11 A <b>That is correct.</b></p> <p>12 Q All right. So what can you tell us, what was</p> <p>13 the injury in your opinion that the motor</p> <p>14 vehicle accident caused here that necessitated</p> <p>15 your surgery?</p> <p>16 A <b>I believe the injury caused damage to the disc</b></p> <p>17 <b>and damage to the facet tissue behind the spinal</b></p> <p>18 <b>cord at that -- at the levels that she had</b></p> <p>19 <b>between 5 and 6.</b></p> <p>20 Q And what objectively can you point us to, what</p> <p>21 CAT scan, what X-ray, what MRI which provides</p> <p>22 support to that opinion?</p> <p>23 A <b>Yeah. Our review of the MRI show that the C5-6</b></p> <p>24 <b>disc was abnormal looking. Additionally,</b></p> <p>25 <b>Dr. Ong's diagnostic studies point to the fact</b></p>	<p>1 <b>wasn't the conclusion that we were jumping to.</b></p> <p>2 <b>And so I think, you know, the</b></p> <p>3 <b>narrative is she approached this in a very</b></p> <p>4 <b>reasonable manner and I think all her providers</b></p> <p>5 <b>approached it reasonably and it wasn't until she</b></p> <p>6 <b>got to the very end where she's, like, "You know</b></p> <p>7 <b>what, I'm not getting 100 -- you know, I'm not</b></p> <p>8 <b>getting the relief I really need, you know,</b></p> <p>9 <b>let's discuss the surgical option." And -- and</b></p> <p>10 <b>we talked about it. You know, there is no</b></p> <p>11 <b>guarantees here.</b></p> <p>12 Q So you often use the phrase "disease" throughout</p> <p>13 your reporting here to describe the area that</p> <p>14 was the situs of the surgery. Why do you call</p> <p>15 it a disease?</p> <p>16 A <b>It's just a general term. It's just -- because</b></p> <p>17 <b>physicians treat disease. You know, I mean,</b></p> <p>18 <b>it's a -- it can be an acute injury or disease.</b></p> <p>19 <b>There is no subtext to that word, meaning that</b></p> <p>20 <b>it's -- you know, I'm not implying that it's not</b></p> <p>21 <b>related to the motor vehicle accident.</b></p> <p>22 Q Is that a common -- common term for surgeons to</p> <p>23 use the word "disease," when they really mean an</p> <p>24 acute injury?</p> <p>25 A <b>Well, I think her injury -- because her</b></p>



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1 injury -- when was her car -- when was her MVA  
 2 accident? When was the surgery? The surgery  
 3 was in 2019. So her accident was, was it in  
 4 twenty --  
 5 Q Her -- the surgery was December 24th, 2019.  
 6 MR. KNOBLOCH: If I may, the accident  
 7 was March 27th of 2017.  
 8 THE WITNESS: Okay. So it's been two  
 9 years; right? Approximately two -- over two  
 10 years. So, I mean, first and foremost, you  
 11 know, we're -- I'm not treating an acute injury,  
 12 you know, because I didn't even meet her until  
 13 well after her motor vehicle accident, so I'm  
 14 not treating an acute injury.  
 15 Number two, you know, we just -- I use  
 16 the word "disease" because that's just -- you  
 17 know, that's an easy term to use. And I think  
 18 that certainly if you want to interpret that to  
 19 mean something different, certainly you could do  
 20 that, but in my mind, you know, she's got pain,  
 21 she's got damage, and that's part of the  
 22 disease. You know, that's part of the problem.  
 23 So "disease" and "problem," you know, in my mind  
 24 are interchangeable.  
 25

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1 BY MR. PAWLAK:  
 2 Q And do you think that's generally accepted in  
 3 the medical profession, to use that term of art  
 4 in such a fashion?  
 5 A I don't know. I mean, it might be. It may not  
 6 be. I don't think it's super critical. I mean,  
 7 perhaps it's critical for you, but I don't think  
 8 it's super critical, because I think I know what  
 9 I'm talking about.  
 10 MR. KNOBLOCH: And I have to correct  
 11 the record. It's march 24th of 2017. I don't  
 12 think it changes his testimony.  
 13 BY MR. PAWLAK:  
 14 Q Okay. So you also talk about degenerative  
 15 changes throughout your reports in terms of  
 16 describing the area that was the situs of the  
 17 surgery, don't you?  
 18 A I may have mentioned some degenerative changes.  
 19 Yeah. I have to see the exact wording and  
 20 language. But, you know, at her age she's  
 21 probably going to have some degenerative  
 22 changes, and I think that is perfectly accurate  
 23 to assume that.  
 24 Q And degenerative changes would be caused by  
 25 disease, aren't those two terms more

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1 interchangeable than --  
 2 A I think to the common layman, yeah, you know,  
 3 and certainly you can push that point. But in  
 4 my interpretation "injury," "damage," "disease,"  
 5 I mean, that's -- you know, that's what I'm  
 6 thinking.  
 7 Q Okay. Now, you talked earlier under direct  
 8 examination that -- if I understood your  
 9 testimony, that Ms. Gard was complaining that  
 10 she wasn't receiving any permanent relief, and  
 11 you talked about providing permanence with  
 12 surgery?  
 13 A That was the goal.  
 14 Q Okay. And, in effect, you only had a 20 percent  
 15 success with that; is that correct?  
 16 A That is correct.  
 17 Q So you did not achieve permanence?  
 18 A I didn't achieve a -- greater than 50 percent,  
 19 which is what I believe to be roughly the  
 20 standard, pain relief. Did we achieve  
 21 permanence? I think permanence is more an issue  
 22 of time. And so if she got 20 percent relief  
 23 forever, then we did achieve permanence -- a  
 24 modest permanence of pain relief.  
 25 So I think for me "permanence" means

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1 time, but I think your question is really the  
 2 degree of permanence or the degree of pain  
 3 relief. No. We didn't achieve a high level of  
 4 pain relief. Did we -- did we achieve pain  
 5 relief forever? We don't know because that --  
 6 you know, we have to wait for that to come  
 7 through the wash.  
 8 Q And you haven't seen Ms. Gard for a significant  
 9 amount of time; right?  
 10 A That is correct.  
 11 Q So you don't know what her situation is today;  
 12 correct?  
 13 A I do not.  
 14 Q All right. Is there any objective evidence out  
 15 there that you can point to that, in fact,  
 16 Ms. Gard's physical abilities have improved  
 17 since you performed the surgery?  
 18 A I don't have any information.  
 19 Q So when you say the goal -- you were -- if I  
 20 understand your testimony, your goal was you  
 21 thought the surgery would be a success if you  
 22 could permanently reduce her pain by 50 percent;  
 23 is that accurate?  
 24 A Yeah. I mean, initially -- so, I mean, the word  
 25 "permanent" means that it's long-lasting

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1 relative to what she was achieving from the  
 2 injections, and the goal was to achieve -- or  
 3 the aim was to get at least 50 percent pain  
 4 relief.  
 5 Q So why didn't you simply recommend that she  
 6 continue with the facet procedures which she had  
 7 achieved significant success with 50 percent  
 8 improvement?  
 9 A Is your question why didn't I recommend that --  
 10 Q Yeah.  
 11 A -- instead of the surgery?  
 12 Q Yeah.  
 13 A We did. We, in fact, recommended that she  
 14 continue that as long as she can. She was not  
 15 getting relief long enough with the facet  
 16 procedures, and facet procedures are --  
 17 especially radiofrequency, over time becomes  
 18 less and less effective.  
 19 Q And is it the same with the ablation procedure?  
 20 A Yes. Yeah. So they become -- over time they  
 21 become less effective.  
 22 Q Is she -- can she undergo these procedures even  
 23 now, after the surgery?  
 24 A Yes. Yes, she can.  
 25 Q How is it that the ablation procedure, which as

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1 I understand you said you -- it removes or it  
 2 desensitizes the nerve endings, do those nerve  
 3 endings grow back eventually?  
 4 A Yes.  
 5 Q You talked earlier -- briefly talked about the  
 6 physical therapy.  
 7 You -- you're not really familiar with  
 8 the physical therapy procedure that she went  
 9 through at all, are you?  
 10 A I'm not a therapist. No.  
 11 Q Okay. You don't know if she missed  
 12 appointments?  
 13 A I do not.  
 14 Q And you don't know if she was urged to schedule  
 15 additional appointments or how hard she worked  
 16 at any of that; right?  
 17 A No. I was not there with her.  
 18 Q So how much have you been paid today for your --  
 19 today and any other cooperation you made with  
 20 the plaintiff for your testimony in this regard?  
 21 A For today, I don't know. I would have to talk  
 22 to my manager. She -- she processes all that.  
 23 Q Okay. Is that your booking agent or your  
 24 manager?  
 25 A Kind of does both.

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1 Q So you don't know what you were paid today.  
 2 Okay. And you don't know if you received any  
 3 payment whatsoever for the surgery that you  
 4 performed?  
 5 A Yeah. I -- I am assuming from Exhibit 9, if  
 6 this is accurate -- and I don't know when this  
 7 was -- so this looks like this was generated in  
 8 March 2021. It says we haven't been paid.  
 9 Q Yeah. Okay.  
 10 A So if we haven't been paid by March 2021, I  
 11 doubt that we got paid, you know, at all.  
 12 MR. PAWLAK: All right. That's all I  
 13 have. Thanks.  
 14 EXAMINATION  
 15 BY MR. KNOBLOCH:  
 16 Q A couple follow-up, Doctor. You have Exhibit 9  
 17 there in front of you. We've had an extensive  
 18 discussion today about the codes and whatnot.  
 19 That discussion also included billing for your  
 20 time and also billing for your assistant or your  
 21 physician assistant's time. I want to talk  
 22 about that concept in general.  
 23 Is it common in your experience,  
 24 Doctor, for neurosurgeons or any surgeon to bill  
 25 for their own time and also bill for an

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1 assistant's time?  
 2 A Yeah. So it depends on the practice. So there  
 3 is a lot of practices where two neurosurgeons  
 4 will work together, and the primary surgeon gets  
 5 paid the lion's share of the fee, and then the  
 6 assistant surgeon will get paid a fraction,  
 7 whatever that may be.  
 8 Because practices have grown, because  
 9 neurosurgeons are in short supply, often  
 10 physician extenders, PAs, are now involved. And  
 11 they -- and they -- what they do is no less  
 12 skilled than what a second neurosurgeon would  
 13 do, you know, and so a really good physician  
 14 assistant can do pretty much what another  
 15 neurosurgeon does. There is a lot of rules and  
 16 regulations that they have to do it under  
 17 supervision, but they're very skilled. So  
 18 that's -- that's how it works.  
 19 Q Is it fair to say with respect to the codes and  
 20 the procedures and what you can bill and how  
 21 much you can bill and what codes for this --  
 22 this, that, and the other thing, are those  
 23 ever-changing within your industry, would you  
 24 say?  
 25 A I mean, the codes can change because it's all

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1 **determined I guess by a larger body that**  
 2 **determines these codes. So the code numbers can**  
 3 **change, but the idea, the principles, don't**  
 4 **change.**  
 5 Q Regardless of your charges and the codes  
 6 associated with them, do you have any reason to  
 7 dispute that Ms. Gard was actually charged --  
 8 looking at Exhibit 9 -- this \$101,527 by your  
 9 office for the totality of the treatment  
 10 received by you?  
 11 A **I mean, yes, I believe that this -- these were**  
 12 **the charges that were sent out.**  
 13 Q What I was getting at is -- well, strike that  
 14 question.  
 15 MR. KNOBLOCH: I would like to move  
 16 those exhibits that I proffered earlier into  
 17 evidence, but subject to that, I have nothing  
 18 further.  
 19 Any objection to that?  
 20 MR. PAWLAK: Well, I don't know if we  
 21 want to keep -- I would like to have a  
 22 discussion with you afterwards, or unless you  
 23 want to do it now on the record now about those  
 24 exhibits.  
 25 MR. KNOBLOCH: Well, how long it is it

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1 going to take? Let's -- I would prefer to do it  
 2 on the record, so we don't have to brief it  
 3 after.  
 4 MR. PAWLAK: Okay. Well, yeah. My  
 5 issue is if your intention is to enter, like,  
 6 for example, the physical therapy records based  
 7 upon the testimony of this witness, yeah, I'm  
 8 opposed to that.  
 9 I'm not necessarily opposed to you --  
 10 to us coming to a stipulation that those records  
 11 can entered on the face of it for what they're  
 12 worth, in the sense that she went to therapy on  
 13 those days. I just object -- he doesn't have  
 14 the foundation, I don't think, to say that  
 15 that's reasonable based upon his -- his, you  
 16 know, carefree review here today, and I don't  
 17 think he possesses the expertise, as he's  
 18 indicated there.  
 19 So, I mean, but I'm -- that being  
 20 said, I think we can come to arrangement to get  
 21 those in. Otherwise you can move and I can  
 22 object and we can let the judge decide, but I  
 23 think we can probably work that, depending on  
 24 what you want to do with those physical -- if  
 25 you just want to --

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1 MR. KNOBLOCH: Is your only objection  
 2 to the therapy records?  
 3 MR. PAWLAK: What was the other one  
 4 that he -- well, all of the other records, too,  
 5 that he testified that were reasonable, it's my  
 6 position that -- I'm not -- I'm not opposed to  
 7 the document coming in for what it says on the  
 8 face of it. I'm -- what I'm objecting to is his  
 9 opinion that they're reasonable.  
 10 Now, we can let those documents in for  
 11 face value, but I'm not agreeing that his  
 12 testimony that they're reasonable is relevant.  
 13 And I guess we can deal with that, if you're  
 14 relying on that for some purpose.  
 15 MR. KNOBLOCH: Well, I'm trying to  
 16 figure out the distinction.  
 17 MR. PAWLAK: Yeah. Yeah.  
 18 MR. KNOBLOCH: It's going to come in  
 19 on its face, so the numbers are going to be  
 20 heard by the Court.  
 21 MR. PAWLAK: The number is going to be  
 22 heard.  
 23 MR. KNOBLOCH: The Court still has to  
 24 make a determination on reasonableness.  
 25 MR. PAWLAK: Yeah.

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1 MR. KNOBLOCH: I think there was  
 2 enough foundation, shaky or not, that his  
 3 testimony comes in, and I think your cross goes  
 4 to the weight of the evidence, not to the  
 5 admissibility of it, so I think it comes in, and  
 6 the judge is going to have to weigh it all --  
 7 MR. PAWLAK: Okay.  
 8 MR. KNOBLOCH: -- and come to a  
 9 reasonable number.  
 10 MR. PAWLAK: I will -- then what I  
 11 will do is I will --  
 12 MR. KNOBLOCH: We're almost done,  
 13 Doctor.  
 14 MR. PAWLAK: Yeah. I'm going to --  
 15 I'm going to keep my objection there, then,  
 16 based upon that provision that it goes to the  
 17 weight of it. So if I think if I -- I'm going  
 18 to have to preserve that objection. If she says  
 19 it comes in and then she decides the weight  
 20 based upon the direct and the cross, then we can  
 21 deal with that. So I'm going to -- I'm going to  
 22 keep my objection.  
 23 MR. KNOBLOCH: As to what  
 24 specifically?  
 25 MR. PAWLAK: Well, I'm going to keep

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1 it to the physical therapy -- I'm going to keep  
 2 it to the physical therapy records. If you're  
 3 relying upon him to get those into the record,  
 4 that's -- that's my -- that's the crux of my  
 5 objection.  
 6 MR. KNOBLOCH: Okay.  
 7 MR. PAWLAK: I don't buy his testimony  
 8 that they're reasonable. If they have to be  
 9 reasonable to come into the record, then I'm  
 10 objecting to it, I guess, because I don't think  
 11 they're reasonable. That's part of my argument  
 12 in this case.  
 13 MR. KNOBLOCH: But we're focused just  
 14 on the therapy at this point?  
 15 MR. PAWLAK: Therapy record and --  
 16 well, of course, all of his charges, too. I  
 17 mean, they're there. I agree that they  
 18 happened, obviously. We know that they were  
 19 billed out. I'm objecting on the issue of their  
 20 reasonableness.  
 21 MR. KNOBLOCH: Sure. You can preserve  
 22 all objections --  
 23 MR. PAWLAK: Okay.  
 24 MR. KNOBLOCH: -- to reasonableness --  
 25 MR. PAWLAK: Yeah.

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1 MR. KNOBLOCH: -- because that's, in  
 2 my mind, a jury question or a Court question --  
 3 MR. PAWLAK: Yeah.  
 4 MR. KNOBLOCH: -- so I don't know if  
 5 you're -- you need to place it.  
 6 But as far as the admissibility of  
 7 these documents, that's what I would like to get  
 8 straightened out here on the record. So I would  
 9 like to move those --  
 10 MR. PAWLAK: Yeah.  
 11 MR. KNOBLOCH: -- into evidence.  
 12 MR. PAWLAK: Okay. That's fine.  
 13 MR. KNOBLOCH: So no objection?  
 14 MR. PAWLAK: I think I've gone over  
 15 backwards trying to preserve my --  
 16 MR. KNOBLOCH: So just to be clear, no  
 17 objection to my exhibits --  
 18 MR. PAWLAK: Coming into the record.  
 19 Right. Yeah.  
 20 MR. KNOBLOCH: Okay.  
 21 MR. PAWLAK: That's fine.  
 22 MR. KNOBLOCH: All right. I think  
 23 we're done.  
 24 MR. PAWLAK: And then I'll -- excuse  
 25 me. I'll move my exhibits in the record, too,

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1 for what they're -- for the same reason. The  
 2 Judge can decide whether or not --  
 3 MR. KNOBLOCH: No objection.  
 4 MR. PAWLAK: -- what weight she wants  
 5 to give them. Okay. Thank you.  
 6 MR. KNOBLOCH: All right. We're done.  
 7 THE VIDEOGRAPHER: We're going off the  
 8 record. The time is 5:15 p.m. This concludes  
 9 today's testimony. The total number of media  
 10 units used today is one.  
 11 (Proceedings concluded at 5:15 p.m.)  
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1 STATE OF WISCONSIN )  
 ) SS:  
 2 COUNTY OF MILWAUKEE )  
 3  
 4 I, Sarah M. Gilkay, RPR, RMR, CRR, and  
 5 Notary Public in and for the State of Wisconsin,  
 6 do hereby certify that the preceding deposition  
 7 was recorded by me and reduced to writing under  
 8 my personal direction.  
 9 I further certify that I am not a  
 10 relative or employee or attorney or counsel of  
 11 any of the parties, or a relative or employee of  
 12 such attorney or counsel, or financially  
 13 interested directly or indirectly in this  
 14 action.  
 15 In witness whereof, I have hereunder  
 16 set my hand and affixed my seal of office on  
 17 this 28th day of February, 2022.  
 18  
 19  
 20  
 21 <%26888,Signature%>  
 22 \_\_\_\_\_  
 23 Sarah Gilkay  
 24 RPR, RMR, CRR, and Notary Public  
 25 My commission expires March 8th, 2026



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